



**Nova Scotia Atlee
Perinatal Database
Coding Manual
13th Edition
(Version 13.0.0)**

April 2009

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LEFT BLANK INTENTIONALLY

LISTING OF HOSPITALS

Hospitals appearing in bold are currently providing maternity services.

	<u>HOSPITAL #</u>
Aberdeen Hospital	
New Glasgow	11
All Saints Hospital	
Springhill	12
Annapolis Community Health Centre	
Annapolis Royal	13
Antepartum Mable	
Home	91
Bayview Memorial Health Center	
Advocate Harbour	58
Buchanan Memorial Hospital	
Neil's Harbour	15
Cape Breton Health Care Complex:	
Glace Bay Site	87
Northside (North Sydney Site)	87
Sydney Site	87
CFB Cornwallis	
Cornwallis	79
CFB Stadacona	
Halifax	78
Chaleur Regional Hospital	
New Brunswick	-10
Colchester Regional Hospital	
Truro	18
Cumberland Regional Healthcare Centre	
Amherst	30
Dartmouth General Hospital	
Dartmouth	65
Digby General Hospital	
Digby	20

LISTING OF HOSPITALS (continued)

Hospitals appearing in bold are currently providing maternity services.

	<u>HOSPITAL #</u>
East Coast Forensic Dartmouth	71
Eastern Memorial Hospital Canso	22
Eastern Shore Memorial Hospital Sheet Harbour	23
Fishermen's Memorial Hospital Lunenburg	24
George Dumont Hospital New Brunswick	-11
Glace Bay Health Care Corporation (See Cape Breton Healthcare Complex)	87
Guysborough Memorial Hospital Guysborough	27
Hants Community Hospital Windsor	37
Health Services Association of the South Shore Bridgewater	14
Home of the Guardian Angel Halifax	88
(Use for discharged to only if Mom and Babe both go to the Home)	
Intended Delivery at home (NOT Attended by a Health Care Professional) Home	-7
Intended Delivery at home (Attended by a Health Care Professional) Home	-8
Inverness Consolidated Memorial Hospital Inverness	34
IWK Health Centre Halifax	86

LISTING OF HOSPITALS (continued)

Hospitals appearing in bold are currently providing maternity services.

	<u>HOSPITAL #</u>
Lillian Fraser Memorial Hospital Tatamagouche	32
Moncton Hospital (The) New Brunswick	-12
Musquodoboit Valley Memorial Hospital Middle Musquodoboit	33
New Waterford Consolidated Hospital New Waterford	63
North Cumberland Memorial Hospital Pugwash	35
Northside General Hospital	87
(See Cape Breton Healthcare Complex)	
Nova Scotia Hospital Dartmouth	77
Point Pleasant Lodge Halifax	64
Prince County Hospital Prince Edward Island	-13
Queen Elizabeth Hospital Prince Edward Island	-14
Queen Elizabeth II Health Sciences Centre Halifax	85
Queens General Hospital Liverpool	38
Roseway Hospital Shelburne	39

LISTING OF HOSPITALS (continued)

Hospitals appearing in bold are currently providing maternity services.

	<u>HOSPITAL #</u>
Sackville Memorial Hospital New Brunswick	-15
Sacred Heart Hospital Cheticamp	47
Self Discharge Home	-6
Soldiers Memorial Hospital Middleton	48
South Cumberland Community Care Centre Parrsboro	49
St. Anne's Hospital Arichat	40
St. Martha's Regional Hospital Antigonish	43
St. Mary's Memorial Hospital Sherbrooke	45
Strait Richmond Hospital Cleveland	68
Sutherland-Harris Memorial Hospital Pictou	50
Twin Oaks Memorial Hospital Musquodoboit Harbour	52
Valley Regional Hospital Kentville	67
Victoria County Memorial Hospital Baddeck	53
Western Kings Memorial Health Centre Berwick	55

LISTING OF HOSPITALS (continued)

Hospitals appearing in bold are currently providing maternity services.

	<u>HOSPITAL #</u>
Western Regional Health Centre	
Yarmouth	56
Hospitals in Alberta	
Alberta	-16
Hospitals in Bermuda	
Bermuda	-31
Hospitals in British Columbia	
British Columbia	-17
Hospitals in Manitoba	
Manitoba	-18
Hospitals in Newfoundland and Labrador	
Newfoundland /and Labrador	-19
Hospitals in New Brunswick (other than those listed)	
New Brunswick	-20
Hospitals in Northwest Territories	
Northwest Territories	-21
Hospitals in Ontario	
Ontario	-22
Hospitals in PEI (other than those listed)	
Prince Edward Island	-23
Hospitals in Quebec	
Quebec	-24
Hospitals in Saskatchewan	
Saskatchewan	-25
Hospitals in United States	
United States	-26
Hospitals in Yukon	
Yukon	-27

LISTING OF HOSPITALS (continued)

Hospitals appearing in bold are currently providing maternity services.

HOSPITAL #

Hospitals in Nunavut	
Nunavut	-28
Hospital not in list	
Non-Specific	-32

ADMISSION INFORMATION

UNIT NUMBER

Patient's hospital unit number.

Found on the health record folder or the '*HOSPITAL ADMISSION FORM*'.

CONTACT HOSPITAL

Hospital in which the chart is being coded. *When the hospital number is associated with a coder user name, this field will be auto-filled.*

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the standard 2 digit provincial codes for hospitals found on pages 10-14.

DISCHARGE DATE

Patient's discharge date from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Patient's discharge time from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'HHMM'.

"HH" is in range 0-23, "MM" is in range 0-59

If Discharge Time is not documented leave Discharge Time blank and code '9' in the field immediately following.

ADMISSION DATE

Patient's admission date to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'YYYYMMDD'.

ADMISSION TIME

Patient's admission time to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'.

"HH" is in range 0-23, "MM" is in range 0-59.

GIVEN NAME(S)

Patient's given name(s).

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME

Patient's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

ADMISSION TYPE

Type of Admission

Found on '*ADMISSION SEPARATION SHEET*'.

- 1 Delivered Admission
- 2 Undelivered Admission
- 3 Postpartum Admission
- 5 Neonatal Admission

PREVIOUS SURNAME

Patient's maiden name or other previous surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

Leave blank for Neonatal Admissions.

This field can be left blank if not documented.

A/S/D NUMBER

Hospital number referring to the patient's present admission.

Found on the patient's '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'CCNNNNNNNN/YY':
where "CC" is the admit type, "NNNNNNNN" is an ascension number related to the number of admissions of the year and "YY" denotes the fiscal year (April 1 to March 31), changing on April 1st of each year. The / has to be entered before the YY denoting the fiscal year.

Zeroes before the ascension number must be entered if number does not have 7 digits, e.g. AS0000123/05.

Code '**999999999999**' for other provincial account numbers, or when unknown.

HEALTH CARD NUMBER

Found on the '*HOSPITAL ADMISSION FORM*'.

Record the patients' **Nova Scotia** Health Card Number or hospital generated '8000' number for;

- Nova Scotia residents admitted without a Nova Scotia Health Card Number
- Patients from outside Nova Scotia

If a Nova Scotia Health Card Number or hospital generated '8000' number is not available, code;

- 0 Nova Scotia patient, card not available
- 0 Armed Forces
- 0 RCMP
- 0 First Nations
- 0 Self-paying
- 1 Patient from outside Nova Scotia

BIRTH DATE

Patient's date of birth.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'YYYYMMDD'

**MUNICIPAL CODE FOR
RESIDENCE**

Patient's municipal code.

Found on the '*HOSPITAL ADMISSION FORM*'.
Code using one of the following:

ANNAPOLIS COUNTY

- 12 Annapolis Municipality
- 13 Annapolis Royal

- 19 Bridgetown
- 49 Middleton

ANTIGONISH COUNTY

- 14 Antigonish Municipality
- 15 Town of Antigonish

CAPE BRETON COUNTY

- 22 Cape Breton Municipality
- 31 Dominion
- 32 Glace Bay
- 45 Louisbourg
- 52 New Waterford
- 53 North Sydney
- 67 Sydney
- 68 Sydney Mines

COLCHESTER COUNTY

- 26 Colchester Municipality
- 65 Stewiacke
- 70 Truro

CUMBERLAND COUNTY

- 11 Amherst
- 27 Cumberland Municipality
- 54 Oxford
- 55 Parrsboro
- 63 Springhill

**MUNICIPAL CODE FOR
RESIDENCE** (con't)

DIGBY COUNTY

- 24 Clare Municipality
- 29 Digby Municipality
- 30 Town of Digby

GUYSBOROUGH COUNTY

- 21 Canso
- 33 Guysborough Municipality
- 50 Mulgrave
- 66 St. Mary's Municipality

HALIFAX COUNTY

- 77 Bedford
- 28 Dartmouth City
- 34 Halifax City
- 35 Halifax Municipality (not Bedford, Dartmouth or Halifax)

HANTS COUNTY

- 38 Hantsport
- 36 East Hants Municipality
- 37 West Hants Municipality
- 73 Windsor

INVERNESS COUNTY

- 39 Inverness Municipality
- 58 Port Hawkesbury

KINGS COUNTY

- 18 Berwick
- 41 Kentville
- 42 Kings Municipality
- 74 Wolfville

LUNENBURG COUNTY

- 20 Bridgewater
- 23 Chester Municipality
- 46 Lunenburg Municipality
- 47 Lunenburg Town
- 48 Mahone Bay

**MUNICIPAL CODE FOR
RESIDENCE** (con't)

PICTOU COUNTY

- 51 New Glasgow
- 56 Pictou Municipality
- 57 Pictou Town
- 64 Stellarton
- 69 Trenton
- 72 Westville

QUEENS COUNTY

- 43 Liverpool
- 59 Queens Municipality

RICHMOND COUNTY

- 60 Richmond Municipality

SHELBURNE COUNTY

- 17 Barrington Municipality
- 25 Clark's Harbour
- 44 Lockeport
- 61 Shelburne Municipality
- 62 Shelburne Town

VICTORIA COUNTY

- 71 Victoria Municipality

YARMOUTH COUNTY

- 16 Argyle Municipality
- 75 Yarmouth Municipality
- 76 Yarmouth Town

MUNICIPAL CODE FOR RESIDENCE (con't)

OUT OF PROVINCE RESIDENTS

- 81 Alberta
- 82 British Columbia
- 83 Manitoba
- 84 New Brunswick
- 85 Newfoundland and Labrador
- 86 Ontario
- 87 Prince Edward Island
- 88 Quebec
- 89 Saskatchewan
- 90 Yukon
- 91 Northwest Territories
- 92 Nunavut
- 97 USA
- 95 Bermuda
- 98 Other countries
- 99 Unknown

MARITAL STATUS

Patient's marital status.

Found on the '*HOSPITAL ADMISSION FORM*' or '*PRENATAL RECORD*'.

Code using one of the following:

- 1 Single
- 2 Married
- 3 Widowed
- 4 Divorced
- 5 Separated
- 6 Common Law
- 7 Unknown

Marital Status will automatically blank out for Neonatal Admissions

ATTENDING CARE PROVIDER

Care Provider most responsible for the patient's care *while in hospital*.

Found on the 'HOSPITAL ADMISSION FORM'.

Code using the Provincial Medical Board Number or Provider Number for Midwives.

Code '88888' if physician is not registered in Nova Scotia.
Code '99999' for unknown.

SEX

For adult patients the sex will automatically fill as **F** for female.

For neonatal admissions select the legal phenotypical sex of the infant regardless of Karyotype.

- F** Female
- M** Male
- A** Ambiguous
- 9** Unknown

STREET ADDRESS

Patient's street address at time of admission

Found on the '*HOSPITAL ADMISSION FORM*'.

Example: 4 King Street

MAIL ADDRESS

Patient's mailing address.

This field can be left blank if mailing address is not documented or same as street address.

Found on the '*HOSPITAL ADMISSION FORM*'.

Example: PO Box 40 or RR#2

CITY/TOWN

Patient's city, town or village of residence.

Found on the '*HOSPITAL ADMISSION FORM*'.

POSTAL CODE

Patient's postal code.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'A1A1A1' where "A" is an alphabetic character and "1" is a number.

Code '**888888**' when the postal code is known and outside of country, e.g. USA, Britain, St. Pierre-Miquelon.

Code '**999999**' for unknown.

PROVINCE/COUNTRY OF RESIDENCE

Patient's province of residence.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the following:

- AB Alberta
- BC British Columbia
- MB Manitoba
- NS Nova Scotia
- NB New Brunswick
- NL Newfoundland and Labrador
- NT Northwest Territories
- NU Nunavut
- ON Ontario
- PE Prince Edward Island
- QC Quebec
- SK Saskatchewan
- YT Yukon
- US USA
- XX Not for Canada or USA

ADMISSION PROCESS STATUS

Indicates the coding status of the admission information.

Code using one of the following:

- 2 Coding of chart in process' *The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 Coding of admission information completed.

Once the case is saved (status 4 or 5) the data can be viewed, but not changed. Status 4 indicates that the data is ready to be transferred, status 5 indicates that data has been transferred.

Once data has been frozen (status 4 or 5), requests for any necessary changes or corrections must be forwarded to the Health Information Coordinator at RCP.

ROUTINE INFORMATION - DELIVERED ADMISSION

DELIVERED ADMISSION

Any admission of a pregnant woman resulting in the delivery of;

1. a live born fetus OR
2. a fetus that has reached 20 or more weeks gestation OR
3. a fetus weighing 500 or more grams OR
4. a fetus that was one of a set of multiples where at least one met any of the previous three criteria.

DELIVERY HOSPITAL

Hospital in which the delivery of the infant took place.

Found on the '*HOSPITAL ADMISSION FORM*' or '*MATERNAL ADMISSION ASSESSMENT FORM*'.

Code using one of the standard 2 digit provincial codes for hospitals found on pages 10-14.

*If an emergency birth occurs in a hospital not providing maternity services, and the mother and baby are transferred to another facility that provides maternity services, the hospital receiving the transfer is responsible for coding the case as a delivered case. In these situations, **the 'Delivery Hospital' should be coded with the hospital number of the facility where the birth actually occurred.***

Code the following for the unusual situations:

- 1 Unplanned out of hospital, e.g. delivery en route to hospital, unplanned birth at home.
- 2 Planned birth at home
- 5 Midwife attended home delivery

ADMITTED FROM

Mother's location immediately prior to admission.

Found on the '*HOSPITAL ADMISSION FORM*'

If patient is transferred from another hospital, record the standard 2 digit provincial code number for that facility found on pages 10-14.

If patient comes from home, code '0'

Code the following for the unusual situations:

- 7 Intended delivery at home without help of a Health Care Provider (not midwife)
- 8 Intended delivery at home with help of a Health Care Provider (not midwife)

If a patient comes from the emergency room of another facility without having been admitted to the facility Code '0' admitted from home.

PRENATAL RECORD ON CHART AT TIME OF CODING

The prenatal record was filed on the chart at the time of coding

Code using one of the following

- Y Yes Prenatal record on chart at time of coding
- N No Prenatal record not on chart at time of coding

**DATE OF LAST NORMAL
MENSTRUAL PERIOD**

Date of patient's last normal menstrual period.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS ASSESSMENT*'.

Use the following format: 'YYYYMMDD'

If the date of the last normal menstrual period is unknown or missing, leave 'LMP date' blank and code '9' in the field immediately following.

If unsure is ticked in the box but a date is given, enter the date given in the field provided.

**PRE-CONCEPTUAL FOLATE
INTAKE**

Maternal pre-conceptual folate intake.

Found on the '*PRENATAL RECORD*'.

Code using one of the following:

Y	Yes
N	No
9	Unknown

GRAVIDA

The number of pregnancies, including the present pregnancy.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT FORM*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '99' for unknown.

PARA

The number of pregnancies, **excluding the present pregnancy**, which resulted in one or more infants weighing 500 grams or more at birth or 20 weeks or greater gestational age (regardless of whether such infants lived, were stillborn or died after birth).

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT FORM*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '**99**' for unknown.

ABORTIONS

The number of pregnancies, **excluding the present pregnancy**, which resulted in a fetus weighing less than 500 grams or, when weight not known, less than 20 weeks gestation, regardless of whether the fetus was born alive.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT FORM*'.

Code '**99**' for unknown.

SPONTANEOUS ABORTIONS

Number of Spontaneous Abortions

Enter the number occurring within the documented category.

Found on the '*PRENATAL RECORD*'

Code '99' for unknown if it is not documented to indicate the number of the category.

THERAPEUTIC ABORTIONS

Number of Therapeutic Abortions

Enter the number occurring within the documented category.

Found on the 'PRENATAL RECORD'

Code '99' for unknown if it is not documented to indicate the number of the category.

UNSPECIFIED ABORTIONS

Number Unspecified as Spontaneous or Therapeutic Abortions

Found on the 'PRENATAL RECORD'

Code '99' for unknown if it is not documented to indicate the number of each category.

**FETAL DEATHS WEIGHING
500 GRAMS OR MORE**

Number of previous fetal deaths specifically recorded as weighing 500 grams or more, and /or equal to or greater than 20 weeks gestation or when documented as a fetal death or stillbirth by the physician.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT FORM*' or the '*PHYSICIANS' ASSESSMENT FORM*'.

Code '9' for unknown.

**NUMBER OF PREVIOUS
NEONATAL DEATHS
WEIGHING 500 GRAMS OR
MORE**

Number of previous neonatal deaths specifically recorded as weighing 500 grams or more or when documented as a neonatal death by the physician.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT FORM*' or the '*PHYSICIANS' ASSESSMENT FORM*'.

Code '9' for unknown.

**NUMBER OF PREVIOUS
C-SECTIONS**

Number of previous C-sections.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT FORM*' or the '*PHYSICIANS' ASSESSMENT FORM*'.

Code '**0**' if no previous C-sections.

Code '**9**' for unknown.

**POSTPARTUM HEMORRHAGE
IN A PREVIOUS PREGNANCY**

Postpartum hemorrhage in a previous pregnancy as stated *and/or* there has been blood loss >500 ml.

Found on the '*PRENATAL RECORD*', or the '*PHYSICIANS ASSESSMENT FORM*' or the '*MATERNAL ADMISSION ASSESSMENT FORM*'.

Code using one of the following:

Y	Yes
N	No
9	Unknown

**PREVIOUS PRE-TERM
DELIVERY**

Number of pre-term deliveries in previous pregnancies.

Found on the '*PRENATAL RECORD*'.

Code the number of deliveries excluding the present pregnancy where the delivery took place less than 36 weeks gestational age.

Code '**9**' for unknown

NUMBER OF PREVIOUS PRE-TERM DELIVERIES IN EACH CATEGORY

Enter the number occurring within the appropriate gestational age category.

Found on the '*PRENATAL RECORD*'.

Previous PTD < 28 6/7 weeks (28 completed weeks)

Previous PTD 29 0/7 to 32 6/7 weeks

Previous PTD 33 0/7 to 36 6/7 weeks

Previous PTD weeks unspecified

NUMBER OF PREVIOUS LOW BIRTH WEIGHT INFANTS

Number of previous infants with birth weight less than or equal to **2499 grams** (5 lbs. 8 oz.).

Found on the '*PRENATAL RECORD*' or the '*PHYSICIANS' ASSESSMENT FORM*'.

Code '**9**' for unknown.

NUMBER OF PREVIOUS OVERWEIGHT INFANTS

Number of previous infants with birth weight greater than **4080 grams** (9 lbs.).

Found on the '*PRENATAL RECORD*' or the '*PHYSICIANS' ASSESSMENT FORM*'.

Code '**9**' for unknown.

PRE-PREGNANCY SMOKING

Number of cigarettes smoked per day before the mother became pregnant.

Found on the '*PRENATAL RECORD*'.

Code the number of cigarettes smoked per day pre-pregnancy, with the following **exceptions**:

- 0 Patient did not smoke pre-pregnancy
- 75 Patient smoked ≥ 75 cigarettes per day pre-pregnancy
- 88 Patient known to be a smoker pre-pregnancy, but number of cigarettes smoked per day is unknown
- 99 Not indicated whether or not the patient smoked pre-pregnancy

NOTE: ½ PACK = 13 CIGS, 1 PACK = 25 CIGS

If the number is recorded in a range, code the highest number, e.g. 10-15 would be coded as 15.

If the number is contradicted on different forms, use the highest number recorded.

**SMOKING AT FIRST
PRENATAL VISIT**

Number of cigarettes smoked per day at the time of the first prenatal visit.

Found on the '*PRENATAL RECORD*'.

Code the number of cigarettes smoked per day at first prenatal visit, with the following **exceptions**:

- 0 Patient did not smoke at the time of the first prenatal visit
- 75 Patient smoked ≥ 75 cigarettes per day at the time of the first prenatal visit
- 88 Patient known to be a smoker pre-pregnancy, but number of cigarettes smoked per day is unknown
- 99 Not indicated at the first prenatal visit whether or not the patient smoked before she was pregnant.

NOTE: ½ PACK = 13 CIGS, 1 PACK = 25 CIGS
If the number is recorded in a range, code the highest number, e.g. 10-15 would be coded as 15.

If the number is contradicted on different forms, use the highest number recorded.

SMOKING AT 20 WEEKS

Number of cigarettes smoked per day at the time of prenatal visit from 18-22 weeks.

Found on the '*PRENATAL RECORD*'.

Code the number of cigarettes smoked per day at the time of prenatal visit from 18-22 weeks, with the following **exceptions:**

- 0 Patient did not smoke at the time of prenatal visit from 18-22 weeks.
- 75 Patient smoked ≥ 75 cigarettes per day at the time of prenatal visit from 18-22 weeks.
- 88 Patient known to be a smoker, but number of cigarettes smoked per day is unknown at the time of prenatal visit from 18-22 weeks.
- 99 Not indicated at the time of prenatal visit from 18-22 weeks or not the patient smoked.

NOTE: ½ PACK = 13 CIGS, 1 PACK = 25 CIGS

If the number is recorded in a range, code the highest number, e.g. 10-15 would be coded as 15.

If the number is contradicted on different forms, use the highest number recorded.

HIGHEST LEVEL OF EDUCATION

Highest level of education completed.

Found on the '*PRENATAL RECORD*'.

- 1 Less than Secondary Education (Some High School)
- 2 Secondary Education (Completion of High School)
- 3 Technical/ Some Post Secondary Education (Community College or working on a Bachelor's Degree)___
- _____4 Post Secondary Education (Completion of a Bachelor's Degree ie. Arts, Commerce or Science)
- 5 Graduate Level (Completion of Masters Degree ie. Masters in Nursing or Education)
- 6 Post Graduate Level (Completion of Doctorate ie. Doctor of Philosophy)
- 7 Professional Degree (ie. Physician, Lawyer, or Dentist)

Code '99' for unknown

MATERNAL RACE/ ETHNICITY

Maternal Race/ Ethnicity.

Found on the '*PRENATAL RECORD*'.

Choose ALL applicable categories documented on the "Prenatal Record"

ACA Acadian
AFC African Canadian
ASN Asian
CAU Caucasian
FNA First Nations
HIS Hispanic
JSH Jewish
MED Mediterranean
MDE Middle Eastern
QUE Quebecois
OTH Other

Code '999' for Unknown

INTENT TO BREASTFEED

Maternal intention to breastfeed.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT FORM*'.

Code using one of the following:

Y Yes
N No
U Unsure

Code '9' for Unknown

PRE-PREGNANCY WEIGHT

Maternal pre-pregnancy weight.

Found on the 'PRENATAL RECORD' or the 'MATERNAL ADMISSION ASSESSMENT FORM'.

This field has been designed to allow either pounds (lbs.) or kilograms (kgs.) to be coded. If the weight is recorded in kilograms, it should be entered in kgs., and 'K' should be coded in the field immediately following, e.g. 60 K.

If the weight is recorded in pounds (lbs.), it should be entered in pounds, and 'P' should be coded in the field immediately following, e.g. 121 P.

If weight not documented as a whole number, round to the nearest whole number.

e.g. 60.2 kg.=60 kg.
60.7 kg.=61 kg.

If weight is recorded in a range, code the highest weight.

e.g. 130-135 lbs. = 135 lbs.

If pre-pregnancy weight is unknown, subtract weight gain from pre-delivery weight.

Code '999' for unknown.

MATERNAL HEIGHT

Maternal Height.

Found on the '*PRENATAL RECORD*'.

Refers to mother's height in feet and inches or centimeters

For measurements in feet and inches round up to the next whole number for inches. Example: 5' 3.5" record as 5' 4".

For measurements in centimeters round up to the next whole number. Example: 150.6cm record as 151cm.

Code '**999**' in the centimeters field for an unknown value.

ATTENDANCE AT PRENATAL CLASSES OR RECEIVED ANY PRENATAL EDUCATION

Maternal attendance at any prenatal classes or education such as videos, seminars or other educational tools

Found on the '*MATERNAL ADMISSION ASSESSMENT FORM*' or the '*PRENATAL RECORD*'

Code for *current* pregnancy only.

Code using one of the following:

Y Yes

N No

Code '9' for unknown

**SMOKING AT TIME OF
ADMISSION**

Number of cigarettes smoked per day at time of the delivery.

Found on the 'MATERNAL ADMISSION ASSESSMENT FORM', the 'MATERNAL NURSING REASSESSMENT FORM' or the 'PHYSICIAN'S ASSESSMENT FORM'.

If none of these forms are present or the information is missing, if the most recent prenatal visit documented is within 7 days of the delivery admission and smoking data were recorded at that visit enter that number.

If there is no information about maternal smoking within 7 days of the delivery admission, code 99 for unknown.

Code the number of cigarettes smoked per day at the time of delivery, with the following **exceptions**:

- 0 Patient did not smoke at the time of delivery
- 75 Patient smoked \geq 75 cigarettes per day at the time of delivery
- 88 Patient known to be a smoker at the time of delivery, but number of cigarettes smoked per day is unknown.
- 99 Not indicated whether or not the patient smoked at the time of delivery.

NOTE: 1/2 PACK = 13 CIGS, 1 PACK = 25 CIGS

If the number is recorded in a range, code the highest number, e.g. 10-15 would be coded as 15.

If the number is contradicted on different forms, use the highest number recorded.

PRESENT WEIGHT

Patient's weight just before delivery.

Found on the '*MATERNAL ADMISSION ASSESSMENT FORM*', **OR** patient's last weight (if within a week of delivery) on the '*PRENATAL RECORD*'.

This field has been designed to allow either pounds (lbs.) or kilograms (kgs.) to be coded. If the weight is recorded in kilograms, it should be entered in kgs., and 'K' should be coded in the field immediately following, e.g. 60 K.

If the weight is recorded in pounds (lbs.), it should be entered in pounds, and 'P' should be coded in the field immediately following, e.g. 121 P.

If weight not documented as a whole number, round to the nearest whole number.

e.g. 60.2 kg = 60 kg
60.7 kg = 61 kg

If weight is recorded in a range, code the highest weight.

e.g. 130-135 lbs = 135 lbs

If present weight is unknown, add pre-pregnancy and weight gain.

Code '**999**' for unknown value.

NUMBER OF FETUSES

Code the number of fetuses which the mother carried to delivery during the present pregnancy.

Found on the '*BIRTH RECORD*' or the '*PRENATAL RECORD*' or the '*PHYSICIANS' ASSESSMENT FORM*' or the '*MATERNAL ADMISSION ASSESSMENT FORM*'..

Use one of the following codes:

- 1 Singleton
- 2 Twins
- 3 Triplets
- 4 Quadruplets
- 5 Quintuplets

MATERNAL ULTRASOUND

Maternal Ultrasound.

Found on an '*ULTRASOUND REPORT*' within the chart.

Indicate Y if an ultrasound report is on the chart. When Y is entered, the ultrasound screen will pop up. Enter appropriate values.

If there is no ultrasound report on the chart but it is documented that the patient had an ultrasound, record **Y** indicating that the patient had an ultrasound and click the box stating ultrasound done but no values recorded.

If there is no ultrasound report on the chart and it is not documented that an ultrasound has been done record **N**.

FETUS NUMBER

This column holds a value to differentiate between ultrasound studies for multiple births.

For singleton pregnancies, the number will always be 1.

In multiple pregnancies, fetus # 1 for first reported baby, fetus # 2 for second, etc.

If there is no indication of an ultrasound being done, leave field blank.

DATE OF FIRST ULTRASOUND

Date of **earliest** ultrasound during this pregnancy where measurements or gestational age of the fetus are recorded.

Found on the '*ULTRASOUND REPORT*'.

Use the following date format: 'YYYYMMDD'.

If there is no indication of an ultrasound being done, leave field blank.

**NO APPLICABLE DATA
RECORDED**

No Applicable Data Recorded

If it is indicated on the chart that an Obstetrical Ultrasound was done but none of the applicable values recorded click the NAD box to indicate this fact.

**CHOOSE APPLICABLE
CATEGORY**

Choose a category dependent on the manner in which the data on the earliest Ultrasound is reported.

Chose Applicable Category:

Measurements
Gestational Age

If the earliest Ultrasound is reported in both category types, choose one and enter the data in that category completely.

**CROWN/RUMP LENGTH
MEASUREMENT**

Crown/rump length recorded as a measurement during the first ultrasound done in this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X' (in centimeters).

Decimal points must be entered.

If the crown/rump length is not recorded on the first ultrasound (with measurements) for this pregnancy, leave this field blank, and record values for the following four variables: **biparietal diameter, head circumference, abdominal circumference, and femur length.**

If the **crown/rump** length is recorded you do not have to fill in the other values.

**BIPARIETAL DIAMETER
MEASUREMENT**

Biparietal diameter recorded as a measurement during the first ultrasound done in this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X' (in centimeters).

Decimal points must be entered.

If the **crown/rump length** measurement has been recorded, leave this field blank.

**HEAD CIRCUMFERENCE
MEASUREMENT**

Head circumference recorded as a measurement during the first ultrasound done in this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X' (in centimeters).

Decimal points must be entered.

If the **crown/rump length** measurement has been recorded, leave this field blank.

**ABDOMINAL
CIRCUMFERENCE
MEASUREMENT**

Abdominal circumference recorded as a measurement during the first ultrasound done in this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X' (in centimeters).

Decimal points must be entered.

If the **crown/rump length** measurement has been recorded, leave this field blank.

**FEMUR LENGTH
MEASUREMENT**

Femur length recorded as a measurement during the first ultrasound done in this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X' (in centimeters).

Decimal points must be entered.

If the **crown/rump length** measurement has been recorded, leave this field blank.

**CROWN/RUMP LENGTH
GESTATIONAL AGE**

Crown/rump length recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: weeks and days.

If the crown/rump length gestational age is not recorded on the first ultrasound (in weeks and days) for this pregnancy, leave this field blank, and record values for the following four variables: **biparietal diameter** gestational age, **head circumference** gestational age, **abdominal circumference** gestational age, and **femur length** gestational age.

If the **crown/rump length** gestational age is recorded you do not have to fill in the other values

BIPARIETAL DIAMETER
GESTATIONAL AGE

Biparietal diameter recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: weeks and days.

If the **crown/rump length** gestational age has been recorded, leave this field blank.

HEAD CIRCUMFERENCE
GESTATIONAL AGE

Head circumference recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: weeks and days.

If the **crown/rump length** gestational age has been recorded, leave this field blank.

ABDOMINAL
CIRCUMFERENCE
GESTATIONAL AGE

Abdominal circumference recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: weeks and days.

If the **crown/rump length** gestational age has been recorded, leave this field blank.

FEMUR LENGTH
GESTATIONAL AGE

Femur length recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: weeks and days.

If the **crown/rump length** gestational age has been recorded, leave this field blank.

MATERNAL SCREENING TEST

Found on 'LAB REPORTS', 'DIAGNOSTIC IMAGING REPORTS' or documented on the 'PRENATAL RECORD'.

Review Lab/Diagnostic Imaging Reports for evidence that specified screening tests were done. If Lab/Diagnostic Imaging Reports are not available, review the Prenatal Record for evidence that the screening was done or not done.

If there is no documentation indicate Unknown.

Group B Strep Screening (usually done at 35-37 weeks)

Y = Yes - done

N = No - not done

U = Unknown

Nuchal Translucency

Y = Yes - done

N = No - not done

U = Unknown

* Nuchal Translucency is an ultrasound review done between 10 and 14 weeks gestation only and reported as nuchal translucency. Do not capture as Yes if noted as nuchal fold or nuchal thickness.

HIV Testing

Y = Yes - done

D = Declined

U = Unknown

N= No - not, done

Maternal Serum

Y = Yes - done

D = Declined

U = Unknown

N= No - not, done

Capture as Yes if only one of the two tests/screens have been completed.

DISCHARGE DATE

Mother's discharge date from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Mother's discharge time from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'HHMM'.

"HH" is in range 0-23, "MM" is in range 0-59.

If discharge time is not documented leave blank and code '9' in the field immediately following.

MOTHER DISCHARGED TO

The immediate destination of patient on discharge.

Found in the '*NURSES' NOTES*' or the '*HOSPITAL ADMISSION FORM*' or the '*PHYSICIANS' ORDER SHEET*'.

Code using one of the standard 2 digit provincial codes for hospitals found on pages 10-14 or use one of the following codes:

- 9 Maternal death
- 0 Home

MATERNAL PRIMARY CAUSE OF DEATH

Found on '*DEATH CERTIFICATE*' or stated by the physician.

This field will grey out if mother lived.

Use **one** of the following options:

- 77777 Lived
- OTHR Other
- PEMB Pulmonary Embolus
- PPHM Postpartum Hemorrhage
- STRK Stroke

AUTOPSY

Completion of maternal autopsy.

Found on the "DEATH CERTIFICATE" or the 'AUTOPSY REPORT'.

Code using one of the following:

- LVD Lived (not applicable)
- Y Died and autopsy done
- N Died but autopsy not done

MATERNAL STEROID THERAPY

Found on the 'MEDICATION SHEET' or on the 'PRENATAL RECORD'

Code the earliest dose of the first course of treatment. For stillbirths, estimate duration of therapy to time of delivery.

In the case of multiples code for birth order 1 only.
Code one of the following:

Dexamethasone

- 1 <24 hours before delivery
- 2 24 to 48 hours before delivery
- 3 >48 hours but less than or equal to 7 days before delivery
- 4 _____ >7 days before delivery
- 5 Unknown when administered

Betamethasone (Celestone)

- 6 _____ <24 hours before delivery
- 7 24 to 48 hours before delivery
- 8 >48 hours but less than or equal to 7 days before delivery
- 9 _____ >7 days before delivery
- 10 Unknown when administered

**ANALGESIA ADMINISTERED
DURING LABOUR**

(Exclude antepartum stillbirths)

Found on the 'BIRTH RECORD', MEDICATION SHEETS' or the PARTOGRAM'.

Choose only one drug and the route administered. Choose the drug administered **closest** to the time of delivery.

Drug

- 1 Demerol (Meperidine)
- 2 Dilaudid (Hydromorphone HCl)
- 3 Fentanyl (Sublimaze)
- 4 Largactil (Chlorpromazine Tranquillizer)
- 5 Morphine (includes Opium; Pantopon)
- 6 Nembutal (Pentobarbital Hypnotic)
- 7 Nubain (Nalbuphine)
- 8 Phenergan (Promethazine Tranquillizer)
- 9 Seconal (Secobarbital)
- 10 Sparine (Promazine Tranquillizer)
- 11 Talwin (Pentazocine)
- 12 Tuinal (Amo-Secobarb Hypnotic)
- 13 Valium (Diazepam Tranquillizer)
- 14 Other Specified Analgesia During Labour

ROUTE OF ADMINISTRATION

Choose only one route of administration for the drug given closest to the time of delivery

- 1 Unknown route, < 1 hr. prior to delivery
- 2 Unknown route, 1 to < 2 hr. prior to delivery
- 3 Unknown route, 2 to 4 hr. prior to delivery
- 4 Unknown route, > 4 hr. prior to delivery
- 5 I.M., < 1 hr. prior to delivery
- 6 I.M., 1 to < 2 hr. prior to delivery
- 7 I.M., 2 to 4 hr. prior to delivery
- 8 I.M., > 4 hr. prior to delivery
- 9 I.V., < 1 hr. prior to delivery
- 10 I.V., 1 to < 2 hr. prior to delivery
- 11 I.V., 2 to 4 hr. prior to delivery
- 12 I.V., > 4 hr. prior to delivery

ANTIBIOTIC THERAPY

Antibiotics administered during a delivered admission.

Found on the '*BIRTH RECORD*', *MEDICATION SHEETS*' or the '*PARTOGRAM*'.

Antibiotics may be given at any time during the delivered admission: Antepartum, Intrapartum or Post-Partum.

Enter a **Y** in all applicable fields.

If no antibiotics were administered, leave **blank**.

Code Y if antibiotic is given during the admission, even if it is for a non-pregnancy related condition.

ANTIBIOTIC DATE

Date antibiotic therapy first given.

Found on '*MEDICATION SHEETS*'.

Use the following format: 'YYYYMMDD'.

Record the date of the first antibiotic therapy given to the mother during the hospital stay.

If date of first antibiotic therapy is not documented, leave date field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the date of the start of the antibiotic before admission, if documented. If the mother was on antibiotics prior to admission and the date not documented, record unknown.

Enter '9' in this field to indicate the date antibiotic therapy first given is missing.

ANTIBIOTIC TIME

Time antibiotic therapy first given.

Found on '*MEDICATION SHEETS*'.

Use the following format:'HHMM'.

'HH' is in range 0-23, 'MM' is in range 0-59.

Record the time of the first antibiotic therapy given to the mother during the hospital stay

If time of first antibiotic therapy is not documented, leave time field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the time of the start of the antibiotic before admission, if documented. If the mother was on antibiotics prior to admission and the time not documented, record unknown.

Enter '9' in this field to indicate the time antibiotic therapy first given is missing.

PROCESS STATUS

Indicates the coding status of delivered routine information.

Select one of the following:

- 2 Coding of chart in process. *The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 Coding of delivered information completed.

Once data has been 'frozen' (status 4 or 5), any necessary changes or corrections must be forwarded to the Health Information Coordinator at RCP.

ROUTINE INFORMATION - LABOUR

BIRTH ORDER

Found on the 'BIRTH RECORD' or the 'OPERATIVE REPORT'.

Use one of the following codes:

- 1 Singleton, or first born of multiples
- 2 Second born of multiples
- 3 Third born of multiples
- 4 Fourth born of multiples
- 5 Fifth born of multiples

DATE OF RUPTURE OF MEMBRANES

Date of rupture of membranes (ROM).

Found on the 'BIRTH RECORD'.

Use the following format: 'YYYYMMDD'.

If there is more than one rupture of membranes, code the earliest date.

If the patient has an elective C-section and there is no history of prior rupture of membranes, use the date of birth as the date of rupture of membranes, since membranes would have been ruptured on the day of delivery.

If the date of rupture of membranes is unknown, leave 'Rupt Date' blank, and code '9' in the field immediately following.

**TIME OF RUPTURE OF
MEMBRANES**

Time of rupture of membranes (ROM).

Found on the 'BIRTH RECORD'.

Use the following format: 'HHMM' where 'HH' is in the range of 0-23 and 'MM' is in the range of 0-59.

If there is more than one rupture of membranes, record the earliest time. If the patient has a C-section and there is no history of prior rupture of membranes, use the time of birth as the time of rupture of membranes, since membranes would have been ruptured at the time of delivery.

When membranes are known to have ruptured within 5 minutes of delivery and the exact time not specified, then the time of birth should be coded as the time of rupture of membranes.

If more than 5 minutes and exact time not specified, then leave 'Rupt Time' blank, and code '9' in the field immediately following.

In situations of long rupture and when the date is known, but the time is not specified, code the appropriate date, leave 'Rupt Time' blank, and code '9' in the field immediately following.

If the time of rupture of membranes is unknown, leave 'Rupt Time' blank, and code '9' in the field immediately following.

TYPE OF RUPTURE OF MEMBRANES

Type of rupture of membranes (ROM).

Found on the 'BIRTH RECORD'.

Code using one of the following:

S Spontaneous
A Artificial
C Suspected
9 Unknown

If there is more than one rupture of membranes, code the type based on the first rupture of membranes.

If the patient has a C-section and there is no history of prior rupture of membranes, code the type of rupture as 'artificial'.

Code Suspected if documented as suspected on the Birth Record with no other documentation of an actual time or date of a spontaneous or artificial rupture of membranes.

MECONIUM STAINING

Meconium staining of the amniotic fluid.

Found on the '*BIRTH RECORD*' or the '*NURSES NOTES*'. Do **not** code **Y** if documentation states 'as noted at time of birth or delivery'.

Code using one of the following:

Y Yes
N No

Code '9' for unknown

LABOUR

Initiation of labour.

Found on the 'BIRTH RECORD' or 'PARTOGRAM'.

Code using one of the following:

- S Spontaneous onset of labour (include augmentation of spontaneous labour)
- I Artificial induction of labour (does not include augmentation of labour)
- N No labour prior to delivery (e.g. elective repeat C-section)
- A Attempted Induction. This is to be used if an attempt at inducing labour has been made but no labour happens. (Failed induction)

*If the cervical dilatation is ≥ 3 cm **and** regular contractions are present when the oxytocin and/or prostin is initiated, code labour as spontaneous (**S**).*

*If the cervical dilatation is < 3 cm **or** there are no regular contractions when the oxytocin and/or prostaglandin is initiated, code labour as induced (**I**).*

**INDICATION FOR INDUCTION
OF LABOUR**

Reason for induction of labour.

Found on the '*BIRTH RECORD*', the '*PHYSICIANS ASSESSMENT FORM*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code using one of the following:

- 0 Not induced
- 1 Elective
- 2 Fetal growth restriction
- 3 Diabetes
- 4 Post dates
- 5 Premature rupture of membranes without chorioamnionitis
- 6 Premature rupture of membranes with clinical chorioamnionitis
- 7 Isoimmunization
- 8 History of precipitate labour
- 9 (Possible) fetal distress; low planning score
- 10 Intrauterine death
- 11 Geographic
- 12 Hypertension
- 13 Other
- 14 Oligohydramnios (decreased amniotic fluid)
- 15 Fetal anomaly
- 16 Polyhydramnios
- 17 Multiple pregnancy
- 18 PUPP
- 19 Cholestatic jaundice
- 20 Thrombocytopenia
- 21 Previous fetal death/poor obstetrical history
- 22 Seizure
- 23 Macrosomia
- 24 No indication given
- 25 Advanced maternal age
- 26 Maternal request
- 27 Vaginal bleeding

**INDUCTION OR ATTEMPT AT
INDUCTION OF LABOUR
PLACE**

Found on the '*BIRTH RECORD*', the '*PHYSICIANS ASSESSMENT FORM*' or the '*MATERNAL ADMISSION ASSESSMENT FORM*'.

- 1 Inpatient
- 2 Outpatient
- 3 Both inpatient and outpatient

Code '9' for unknown

**INDUCTION OR ATTEMPT AT
INDUCTION OF LABOUR
(METHODS/AGENTS)**

Found on the '*BIRTH RECORD*', the '*PHYSICIANS ASSESSMENT FORM*', or the '*MATERNAL ADMISSION ASSESSMENT FORM*'.

If labour was induced, enter "Y" for each documented method/agent used in an attempt to induce labour.

Artificial rupture of membranes, if clearly stated to induce labour

Y = Yes

Cervical Catheter

Y = Yes

Oxytocin

Y = Yes

If Oxytocin is given, when you enter Y, the date and time fields immediately following will open to be entered.

OXYTOCIN DATE

Date oxytocin therapy first given.

Found on 'PARTOGRAM'.

Use the following format:'YYYYMMDD'.

If date of Oxytocin therapy is not documented, leave date field blank and enter '9' in the field immediately following.

If Oxytocin is administered more than one time during a delivered admission, record the date of the administration that started labour and resulted in the delivery of an infant(s).

OXYTOCIN TIME

Time oxytocin therapy first given.

Found on 'PARTOGRAM'.

Use the following format:'HHMM'.

'HH' is in the range of 0-23, 'MM' is in the range of 0-59.

If time of Oxytocin therapy is not documented, leave time field blank and enter '9' in the field immediately following.

If Oxytocin is administered more than one time during a delivered admission, record the time of the administration that started labour and resulted in the delivery of an infant(s).

**INDUCTION OR ATTEMPT AT
INDUCTION OF LABOUR
METHODS/AGENTS**
(con't)

Prostaglandin Oral
Y = Yes

Prostaglandin Vaginal or Cervical
Y = Yes

Other Specified Agents
Y = Yes

If method/agent of induction is **not known or documented**, code 9 in the Artificial Rupture of Membranes field to indicate Unknown.

**DATE OF ADMISSION TO
LABOUR/DELIVERY ROOM**

Date of admission to the labour and delivery room and delivered before discharged from the unit.

Found on the '*PARTOGRAM*' or the '*PROGRESS NOTES*' or '*MATERNAL ADMISSION ASSESSMENT FORM*'.

Use the following format: 'YYYYMMDD'.

If date of admission to LDR is unknown, leave 'LDR Date' blank, and code '9' in the field immediately following.

**TIME OF ADMISSION TO
LABOUR/DELIVERY ROOM**

Time of admission to the labour and delivery room and delivered before discharged from the unit.

Found on the '*PARTOGRAM*' or the '*PROGRESS NOTES*' or the '*MATERNAL ADMISSION ASSESSMENT FORM*'.

Use the following format: 'HHMM'. 'HH' is in range 0-23, 'MM' is in range 0-59.

If time of admission to LDR is unknown, leave 'LDR time' blank, and code '9' in the field immediately following.

**DILATATION AT TIME OF
ADMISSION TO
LABOUR/DELIVERY ROOM**

Cervical dilatation at admission to the labour and delivery room and delivered before discharge from the unit.

Found on the '*PARTOGRAM*'.

Code using the following format: 'XX' where 'XX' represents the dilatation in centimeters.

Code the first dilatation recorded within 2 hours of admission to the LDR. Round the dilatation down to the nearest centimeter, e.g. 3.5 would be coded as 3.

Code '99' for unknown.

MEDICAL AUGMENTATION

Use of Oxytocin to improve contractions after labour has started spontaneously.

Found on the '*PARTOGRAM*' or '*BIRTH RECORD*'.

Code using one of the following:

Y	Yes
N	No
9	Unknown
7	Not applicable

**DATE OF MEDICAL
AUGMENTATION**

Date of initiation of Oxytocin administration for medical augmentation.

Found on the '*PARTOGRAM*'.

Use the following format: 'YYYYMMDD'

If date of medical augmentation is unknown, leave 'Aug Date' blank, and code '9' in the field immediately following.

TIME OF MEDICAL AUGMENTATION

Time of initiation of Oxytocin administration for medical augmentation.

Found on the 'PARTOGRAM'.

Use the following format: 'HHMM'. 'HH' is in the range 0-23, 'MM' is in range 0-59.

If the time of initiation of oxytocin is the same as the time of admission to LDR, code the augmentation time as one minute after the admission time.

If time of medical augmentation is unknown, leave 'Aug Time' blank, and code '9' in the field immediately following.

CERVICAL DILATION AT TIME OF MEDICAL AUGMENTATION

Cervical dilatation at time of medical augmentation.

Found on the 'PARTOGRAM'.

Code using the following format: 'XX' where 'XX' represents the dilation in centimeters.

Round the dilatation down to the nearest centimeter, e.g. 3.5 would be coded as 3.

If the dilatation is not documented, code the last dilatation recorded during the two hours prior to the initiation of the Oxytocin.

If the dilatation is not recorded during this time frame, code '99'.

If the dilatation is noted to be less than dilatation on admission to LDR, code the dilatation at time of augmentation as noted, and change the dilatation on admission to LDR to the same lower dilatation.

Code '99' for unknown.

**DATE WHEN CERVICAL
DILATATION AT 4
CENTIMETRES**

Date when cervical dilatation at 4 cm.

Found on the '*PARTOGRAM*' or the '*PROGRESS NOTES*'.

Use the following format: 'YYYYMMDD'.

Code when first indicated by physician or nurse.

If the patient goes into labour, but has a C-section AND dilatation at C-section is <4 cm, leave '4 cm date' blank, and code '7' in the field immediately following.

If date cervical dilatation at 4 cm is unknown, leave '4 cm date' blank, and code '9' in the field immediately following.

**TIME WHEN CERVICAL
DILATATION AT 4
CENTIMETRES**

Time when cervical dilatation at 4 cm.

Found on the '*PARTOGRAM*' or the '*PROGRESS NOTES*'.

Use the following format: 'HHMM'. 'HH' is in the range 0-23, 'MM' is in range 0-59.

Code when first indicated by physician or nurse.

If not recorded on the Partogram, but dilatation before and after 4 cm is recorded, estimate the time when dilatation would have been 4 cm.

If the patient goes into labour, but has a C-section AND dilatation at C-section is <4 cm, leave '4 centimetres time' blank, and code '7' in the field immediately following.

If time cervical dilatation at 4 cm is unknown, leave '4 centimetres time' blank, and code '9' in the field immediately following.

**DATE OF ONSET OF SECOND
STAGE OF LABOUR**

Defined as full cervical dilatation (10 cm).

Found on the '*BIRTH RECORD*'.

Use the following format: 'YYYYMMDD'.

If the patient goes into labour, but does not get to second stage prior to having C-section, leave 'Stage 2 Date' blank, and code '7' in the field immediately following.

If date of stage 2 is unknown, leave 'Stage 2 Date' blank, and code '9' in the field immediately following.

**TIME OF ONSET OF SECOND
STAGE OF LABOUR**

Defined as full cervical dilatation (10 cms).

Found on the '*BIRTH RECORD*'.

Use the following format: 'HHMM'.

"HH" is in the range 0-23, "MM" is in range 0-59.

If the patient goes into labour, but does not get to second stage prior to having a C-section, leave 'Stage 2 Time' blank, and code '7' in the field immediately following.

If time of stage 2 is unknown, leave 'Stage 2 Time' blank, and code '9' in the field immediately following.

MODE OF DELIVERY

Mode of delivery.

Found on the '*OPERATIVE REPORT*' or the '*BIRTH RECORD*'

Code using **one** of the following:

- ABD Abdominal
- CSC C-section, combined transverse and vertical incision
- inverted T and J incision. (This refers to the uterine
incision, not skin incision.)
- CSH C-section/hysterectomy
- CST C-section, transverse incision
- CSV C-section, classical incision (vertical incision in the
body of uterus)
- CSU C-section, type unknown
- LVS C-section, low vertical incision
- VAG Vaginal

METHOD OF DELIVERY

Method of delivery.

Found on the '*OPERATIVE REPORT*' or the '*BIRTH RECORD*'

Code using **one** of the following:

ABR	Assisted breech
ACH	Forceps to after-coming head (Breech - vaginal delivery only)
BRE	Breech extraction (Vaginal delivery only)
CSF	C-section with forceps
CSV	C-section with vacuum
CSC	C-section with vacuum and forceps
CSN	C-section
FAF	Failed forceps or failed trial of forceps followed by C-section
FCF	Failed forceps followed by C-section with forceps
FVC	Attempted forceps and vacuum followed by C-section using forceps and/or vacuum
FVV	Attempted forceps followed by vacuum vaginal delivery
HIF	High forceps
LMF	Low-mid forceps
LOF	Low or outlet forceps
MIF	Mid-forceps
PVE	Podalic version and extraction (Do not use for C-section)
SPT	Spontaneous vaginal
VAC	Vacuum followed by C-section
VAF	Vacuum followed by forceps
VEX	Vacuum extraction, malstrum extraction
VFC	Vacuum followed by forceps and then C-section
VCV	Attempted vacuum followed by C-section using forceps and/or vacuum
999	Unknown method of delivery

**CERVICAL DILATATION
DURING LAST EXAM PRIOR
TO C-SECTION**

Cervical dilatation during last exam prior to C-section.

Found on the '*PARTOGRAM*' or the '*PROGRESS NOTES*'.

Code using the following format: 'XX' where 'XX' represents the dilation in centimeters.

Round the dilatation down to the nearest centimeter, e.g. 3.5 would be coded as 3.

Code '**99**' for unknown.

POSITION AT DELIVERY

Position of infant at delivery.

Found on the '*OPERATIVE REPORT*', or the '*BIRTH RECORD*'.

Code using **one** of the following:

BCH Breech, other or unspecified
BOW Brow
CPD Compound presentation
FAC Face
FRB Frank breech
FTB Footling breech
POP Persistent occiput posterior (ROP, LOP, OP)
SHL Shoulder presentation
VTX Vertex (includes LOA, ROA, OT, ROT, LOT, OA, Transverse)
999 Unknown

*If the position at delivery is not noted on any of the above forms, and the fetal position recorded on the '*PRENATAL RECORD*' throughout the pregnancy is VTX, and the fetal position recorded on the '*PHYSICIANS' ASSESSMENT FORM*' when the patient is admitted for delivery is vertex, code VTX.*

If the position has been rotated during the delivery or prior to delivery, code the position the baby is currently in at the time of delivery. For example was POP and manually rotated to LOA in time of delivery. Code position at delivery as LOA

EPISIOTOMY

Episiotomy.

Found on the '*BIRTH RECORD*' or the '*OPERATIVE REPORT*'.

Code using **one** of the following:

- 0 Not done
- 4 Medio-lateral
- 6 Midline
- 9 Unknown

BIRTH WEIGHT

Infant's birth weight. First weight noted after birth.

Found on the '*BIRTH RECORD*' or the '*NEWBORN WEIGHT GRAPH*' in grams.

If an infant (≥ 500 gms or gest. ≥ 20 weeks) was born dead or died after birth and was not weighed, code '**9999**'.

For Siamese twins, split weight between babies.

If a baby has a tumour or growth at time of birth and the tumour or growth is removed shortly after, record actual weight at birth, including tumour or growth.

DO NOT take from Pathology Report.

Code '**9999**' for unknown.

APGAR SCORE AT 1 MINUTE

APGAR score at 1 minute.

Found on the '*BIRTH RECORD*'.

Code between 0 and 10 for APGAR score.

Code '**99**' for unknown.

'**77**' for fetal death will autofill

APGAR SCORE AT 5 MINUTES

APGAR score at 5 minutes

Found on the '*BIRTH RECORD*'.

Code between 0 and 10 for APGAR score.

Code '**99**' for unknown.

'**77**' for fetal death will autofill

**APGAR SCORE AT 10
MINUTES**

APGAR score at 10 minutes.

Found on the '*BIRTH RECORD*'.

Code between 0 and 10 for APGAR score.

Code '**99**' for unknown.

'**77**' for fetal death will autofill

CARE PROVIDER ATTENDING DELIVERY

The care provider attending the delivery.

Found on the 'BIRTH RECORD' or the 'OPERATIVE RECORD'.

Code using the Provincial Medical Board Number or Provider Number for Midwives.

Code '88888' - if physician is not registered in Nova Scotia.
Code '99999' - if unknown.

PRIMARY INDICATION FOR C-SECTION

Primary Indication for C-Section.

Found on the "OPERATIVE RECORD" or the BIRTH RECORD" or the 'PROGRESS NOTES' or the 'CONSULTATION NOTE'.

Code using one of the following:

AMA	Advanced Maternal Age
APL	Abruption placenta
BCH	Breech
DBT	Diabetes
CXD	Diseases of the cervix
DYS	Dystocia (Cephalopelvic disproportion, (C.P.D.), Failure-to-progress, Maternal exhaustion, Cervical stenosis POP, OP)
FID	Failed induction
FDS	Fetal distress
FGT	Fetal growth restriction (retardation)
HIV	Human Immunodeficiency Virus
HSV	Maternal herpes simplex infection
HTD	Hypertensive disorders
ISO	Isoimmunization
MAT	Maternal choice
MLP	Malpresentation (e.g. shoulder, brow, face; exclude breech and transverse lie)
MTP	Multiple pregnancy
OCC	Other obstetrical conditions
OFC	Other fetal conditions
PCS	Previous C-section
PLC	Prolapsed cord
PLP	Placenta previa

PRIMARY INDICATION FOR C-SECTION (con't)

PMC	Postmortem C-section
PRM	Prolonged rupture of membranes
SFA	Suspected fetal anomaly
SUR	Suspected/imminent uterine rupture
TLI	Transverse Lie (include unstable lie and oblique lie)
UTS	Uterine surgery, previous
VAG	Vaginal delivery (i.e. not applicable)
999	Unknown

ROUTINE INFORMATION - INFANT

INFANT'S UNIT NUMBER

Infant's hospital unit number.

Found on the health record folder or the '*HOSPITAL ADMISSION FORM*'

In a fetal death this field will auto fill '*7777777777*'.

GIVEN NAME(S)

Infant's given name(s).

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME

Infant's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

SEX

The legal phenotypic sex of the infant, regardless of karyotype.

Found on the '*BIRTH RECORD*'.

Code using one of the following:

F	Female
M	Male
A	Ambiguous

DATE OF INFANT'S BIRTH

Date of infant's birth.

Found on the '*BIRTH RECORD*'.

Use the following format: 'YYYYMMDD'.

If the date of infant's birth is unknown, leave 'birth date' blank, and code '9' in the field immediately following.

TIME OF INFANT'S BIRTH

Time of infant's birth.

Found on the '*BIRTH RECORD*'.

Use the following format: 'HHMM'.

"HH" is in the range 0-23, "MM" is in range 0-59.

If the time of infant's birth is unknown, leave 'birth time' blank, and code '9' in the field immediately following. _____

**DATE OF INFANT'S
ADMISSION TO HOSPITAL**

Date of infant's admission to hospital

Found on the '*HOSPITAL ADMISSION FORM*'

Date of infant's admission to hospital where abstract is coded. Will usually be the same as the birth date. Will be different when the baby was born at home and subsequently needed to be admitted to hospital; en route to hospital; or in a non-obstetric hospital.

Use the following format: 'YYYYMMDD'

**BABY NOT ADMITTED TO
HOSPITAL**

If Infant was not admitted to hospital but Mother was, contact RCP Health Information Coordinator

**TIME OF INFANT'S
ADMISSION TO HOSPITAL**

Time of infant's admission to hospital.

Found on the '*HOSPITAL ADMISSION SHEET*'

Time of infant's admission to hospital where abstract is coded. Will usually be the same as the birth time. Will be different when the baby was born at home and subsequently needed to be admitted to hospital; en route to hospital; or in a non-obstetric hospital.

Use the following format 'HHMM'.

'HH' is in the range of 0-23, 'MM' is in the range of 0-59.

TIME OF FETAL DEATH

When fetal death occurred.

Found on the '*BIRTH RECORD*' or the '*AUTOPSY REPORT*'.

Code using one of the following:

AA	After admission and before labour
BA	Before admission
IP	Intrapartum
NA	Not applicable
UK	Unknown

INFANT A/S/D NUMBER

Hospital number referring to the infant's present admission

Found on the infant's 'HOSPITAL ADMISSION FORM'

Use the following format: 'CCNNNNNNN/YY' where "CC" is the admit type, "NNNNNNN" is an ascension number related to the number of admissions of the year and "YY" denotes the fiscal year (April 1 to March 31), changing on April 1st of each year. The / has to be entered before the YY denoting the fiscal year.

Zeroes before the ascension number must be entered if number does not have 7 digits, e.g. AS0000123/05.

Code **999999999** for unknown value.

In a fetal death this field will autofill to **'77777777777'**.

INFANT'S HEALTH CARD NUMBER

Infant's health card number.

Found on the '*HOSPITAL ADMISSION FORM*'.

Record the patients **Nova Scotia** Health Card Number or the hospital generated '8000' number for;

Nova Scotia residents admitted without a Nova Scotia Health Card Number

Patients from outside Nova Scotia

If a Nova Scotia Health Card Number or hospital generated '8000' number is not available, code;

- 0 Nova Scotia patient, card not available
- 0 Armed Forces
- 0 RCMP
- 0 First Nations
- 0 Self-paying
- 1 Patient from outside Nova Scotia
- 7 will auto fill for fetal deaths

INFANT'S ATTENDING CARE PROVIDER(PMB#)

Care provider most responsible for care of the infant while in hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Number or Provider Number for Midwives.

Code '**8888**' if physician is not registered in Nova Scotia. Code '**9999**' for unknown.

In a fetal death this field will autofill to '**7777**'.

INFANT LENGTH

Found on '*PHYSICIANS NEWBORN ASSESSMENT FORM*' or '*NEWBORN NURSING ASSESSMENT FORM*'.

Refers to infant length in centimeters (cm).

Enter length in centimetres, rounding to the closest whole number. Example: 51.7 cms record as 52 cms.

Enter '**99**' for an unknown value.

HEAD CIRCUMFERENCE

Found on '*PHYSICIANS NEWBORN EXAMINATION FORM*' or '*NEWBORN NURSING ASSESSMENT FORM*'.

Refers to infant head circumference in centimeters (cm).

Enter head circumference in centimeters, rounding to the closest whole number. Example: 39.7 cms record as 40 cms.

Enter '**99**' for an unknown value.

CLINICAL ESTIMATE OF GESTATIONAL AGE

The closest approximation in weeks to the gestational age obtained by physical examination of the infant.

Found on the '*PHYSICIAN NEWBORN EXAMINATION FORM*' or the '*NEWBORN BIRTH ASSESSMENT FORM*' or clearly stated by the physician.

Code stated number of completed weeks. The following is a guide:

Documented as....	Use:
38+ weeks	38
38-40 weeks	39
38-39 weeks	38
> 39 weeks	39
Term	40
Not documented	99 (unknown)

SCN ADMISSION

Infant admitted to the Special Care Nursery; or infants requiring special care in normal nursery where premature nursery not available.

Found in the '*PROGRESS NOTES*'.

Code using one of the following:

Y Yes
N No

If 'Y' is entered, complete the SCN screen by entering the admit and discharge dates to and from the Special Care Nursery.

If there is more than one admission and discharge to the Special Care Nursery during the same admission, enter the dates of the second in the next row. Continue until all SCN admissions are recorded.

OUTCOME OF INFANT

Outcome of infant at time of discharge.

Found on the 'INFANT'S PROGRESS NOTES'.

Code using one of the following:

- LVD Infant lived to be discharged from hospital
- NND Liveborn infant who died before being discharged home from hospital
- FTD Fetal death before birth

BREASTFEEDING

Record one of the following to indicate the method of feeding during the hospital stay.

Found in the '*NURSES' NOTES*' or the '*PHYSICIAN NEWBORN ADMISSION FORM*' or the '*DISCHARGE FORM*'.

Code using one of the following:

- E Breast milk was exclusively given, breast milk, or expressed breast milk (EBM) during the hospital stay
- Cannot be given any food or liquid other than breast milk. Exception: May be given undiluted drops of syrups consisting of vitamins, mineral supplements, or medicines. Breast milk may be given by the mother, health care provider or family member/supporter.
- If the baby was given breast milk and water or glucose water record as breast milk and formula*
- N Baby was not given any breast milk or expressed breast milk during hospital stay
- S Baby was given both breast milk and other supplements, e.g formula, water, glucose water during hospital stay
- 9 There is no documentation as to how the baby was fed during the hospital stay

EARLY BREAST CONTACT

Found on the '*PARTOGRAM OR NURSES NOTES*'

Code using one of the following:

- Y Yes, if the fields Nuzzling/Licking, Attempting Sucking/Good Latch, Vigorous Sucking/Good Latch are checked on the Partogram and there was contact within one hour of delivery
- N No, if none of the above boxes are checked or if noted baby asleep and it has not been documented there was breast contact within 1 hour of delivery
- 9 Unknown, if none of the applicable boxes are checked and there is no noted breast contact within the first hour of delivery

INFANT'S DISCHARGE DATE

Discharge date of infant's admission to the hospital of birth.

Found in the '*NURSES NOTES*'.

Use the following format: 'YYYYMMDD'.

If the date of infant's discharge is unknown, leave 'Infant's Discharge Date' blank, and code '9' in the field immediately following.

INFANT'S DISCHARGE TIME

Discharge time of infant's admission to the hospital of birth.

Found in the '*NURSES' NOTES*'.

Use the following format: 'HHMM'. "HH" is in the range 0-23, "MM" is in range 0-59,

If the time of infant's discharge is unknown, leave 'Infant's Discharge Time' blank, and code '9' in the field immediately following.

DISCHARGED TO

Immediate destination of infant on discharge from hospital.

Found in the '*PHYSICIANS' PROGRESS NOTES*' or the '*NURSES' NOTES*' OR THE '*PHYSICIANS ORDER SHEET*'.

Code using one of the standard 2- digit provincial codes for hospitals found on pages 10-14 or use one of the following codes:

- 0 Home
- 9 Infant Death

AUTOPSY

Completion of infant autopsy.

Found on the '*NEWBORN CODING SHEET*' "*DEATH CERTIFICATE*" or the '*AUTOPSY REPORT*'.

Code using one of the following:

- LVD Lived (not applicable)
- Y Died and autopsy done
- N Died but autopsy not done

**INFANT'S PRIMARY CAUSE
OF DEATH**

Found on the 'AUTOPSY REPORT' or stated by the physician.

Use **one** of the following codes:

7777	Infant lived
ABRP	Abruptio placenta
ANEC	Acute necrotizing enterocolitis
OAIR	Airway failure
AMNO	Amniocentesis
ANAL	Analgesia or anaesthesia
ASPN	Aspiration
CPDP	Chronic pulmonary disease
COTR	Complications of treatment
ANOM	Congenital anomaly
CRLK	Cord loops and/or knots
CDOT	Cord, miscellaneous
CORP	Cord prolapse
DBRN	Degenerative brain disease
DUCT	Ductus syndrome of prematurity
EXTX	Exchange transfusion
FETH	Fetal hemorrhage
FMAL	Fetal malnutrition
HMDD	Hyaline membrane disease
HYDR	Idiopathic hydrops
IBOM	Inborn errors of metabolism
INFT	Infection
IVTF	Intravascular transfusion
ISOM	Isoimmunization
KERN	Kernicterus
MALP	Malpresentation
DIAB	Maternal diabetes
SHOC	Maternal shock
MUSF	Multi-system failure
MINF	Myocardial infarction
NEOP	Neoplasia
TTTX	Twin-to-twin transfusion (Parabiotic syndrome)
PPFC	Persistent fetal circulation
PLPV	Placenta previa

INFANT'S PRIMARY CAUSE OF DEATH (con't)

AIRL	Pneumothorax pneumomediastinum and/or pneumopericardium
PIVH	Primary intraventricular hemorrhage
PPHN	Primary Pulmonary hypertension
PULH	Primary pulmonary hemorrhage
RUPU	Ruptured uterus
SIDS	Sudden Infant death syndrom
THAB	Therapeutic abortions
TOXM	Toxemia
TRAS	Tracheal stenosis
TRAU	Trauma (obstetrical)
UNEX	Unexplained
UXPA	Unexplained peripartum asphyxia
VOLV	Acquired volvulus

DATE OF DEATH

Date of infant's death.

Found in the '*NURSES' NOTES*' or the '*NEWBORN CODING SHEET*'.

Use the following format: 'YYYYMMDD'.

If death date is unknown, leave blank and code '9' in the field immediately following.

TIME OF DEATH

Time of infant's death.

Found in the '*NURSES' NOTES*', or the '*NEWBORN CODING SHEET*'.

Use the following format: 'HHMM'.

'HH' is in the range 0-23, 'MM' is in range 0-59.

If death time is unknown, leave blank and code '9' in the field immediately following.

CORD ARTERY pH

Cord artery pH completed.

Found on the '*LAB REPORTS*' or the '*PROGRESS NOTES*'.

Code using one of the following:

Y	Yes
N	No
9	Unknown

CORD ARTERY pH VALUE

Cord artery pH value.

Found on the '*LAB REPORTS*'.

Use the following format: 'X.XX'

Decimal point must be entered if the value is not a whole number e.g. 7.14.

If the value is a whole number, enter that number e.g. 7.

Allowed range is 6.4 to 7.8.

If it is outside this range and valid contact the RCP Health Information Coordinator.

Code '99' for unknown

77 will autofill for not applicable or fetal death.

pCO₂ VALUE

pCO₂ value.

Found on the '*LAB REPORTS*'

Use the following format: 'XXX.X'

Decimal points must be entered if the value is not a whole number e.g. 56.9.

If the value is a whole number, enter that number e.g. 56.

Allowed range is 0 to 130.

If it is outside this range and valid contact the RCP Health Information Coordinator.

Code '999' for unknown.

777 will autofill for not applicable or fetal death.

BASE EXCESS VALUE

Base excess value.

Found on the '*LAB REPORTS*'

Use the following format: 'YXX' where Y is a negative sign (-) and 'XX' is the value or 'XX' where the value is positive.

Allowed range is 10 to -30

If it is outside this range and valid contact the RCP Health Information Coordinator.

Code '99' for unknown.

77 will autofill for not applicable or fetal death.

**FETAL MALNUTRITION/SOFT
TISSUE WASTING**

Fetal malnutrition or soft tissue wasting.

Found in the '*DISCHARGE SUMMARY*' or
NEONATOLOGIST'S LISTING'

Choose one of the following:

- 1 Moderate Wasting
- 2 Severe Wasting

TWIN TYPE

Found on the '*DISCHARGE SUMMARY*' or
NEONATOLOGIST'S LISTING'

Choose one from the following list:

- 1 Monoamniotic (one amniotic sac)
- 2 Monochorionic, diamniotic
- 3 Dichorionic, dissimilar sexes or blood groups
- 4 Dichorionic, similar sexes and blood groups
- 5 Dichorionic, similar sexes, blood groups
undetermined
- 6 Undetermined
- 7 Siamese (Conjoined) twins

DEPRESSION AT BIRTH

Found on the '*BIRTH RECORD*', '*DISCHARGE SUMMARY*' or '*NEONATOLOGIST'S LISTING*'

Depression at birth, requiring intermittent positive pressure breathing. If both mask and tube are used from resuscitation, code as resuscitation by tube. Code the duration as the sum of both the mask and tube resuscitation. Or if masked and stopped and restarted again, code combined time of mask.

Code one of the following:

Bag and Mask

- 1 <1 minute
- 2 1 to 3 minutes
- 3 >3 minutes
- 4 Unknown duration

Endotracheal tube

- 5 <1 minute
- 6 1 to 3 minute
- 7 >3 minutes
- 8 Unknown duration

CPAP/T-Piece/Neopuff

- 9 <1 minute
- 10 1 to 3 minute
- 11 >3 minutes
- 12 Unknown duration

ELECTIVE NON-RESUSCITATION

Found on the '*DISCHARGE SUMMARY*' or '*NEONATOLOGIST'S LISTING*'.

Choose from the following list:

- 1 Do not resuscitate order on chart
- 2 Withdrawal of ventilator care with do not resuscitate order on chart
- 3 Non-resuscitation in labour and delivery room

RETINOPATHY OF PREMATURITY

Found on the '*DISCHARGE SUMMARY*'.

Code one of the following:

- 1 Stage 1 Peripheral vascular straightening
- 2 Stage 2 Peripheral shunt well seen
- 3 Stage 3 Vessels growing into vitreous
- 4 Stage 4 Retinal detachment

**CHROMOSOMAL
ABNORMALITIES**

Found on '*GENETICS REPORT*' or
'NEONATOLOGIST LISTING'

Code one chromosomal abnormality from the listing:

- 1 Aneuploidy
- 2 Chimerism
- 3 Mosaicism
- 4 Triploidy
- 5 Deletion
- 6 Duplication
- 7 Microdeletion
- 8 Monosomy
- 9 Ring
- 10 Tandem repeat
- 11 Trisomy
- 12 Uniparental disomy
- 13 Translocation

Please note that chromosome numbers are from 1 to 23 and X and Y.

If Aneuploidy, Chimerism or Triploidy are selected you DO NOT have to code the chromosome affected, the affected arm (p or q) or the site on the arm.

If Mosaicism, Deletion, Duplication, Microdeletion, Monosomy, Ring, Tandem Repeat, Trisomy or Uniparental Disomy are selected code also the affected chromosome. You DO NOT have to code the affected arm (p or q) or the site on the arm if not documented.

If Translocation is selected two chromosomes should be coded. You DO NOT have to code the affected arm (p or q) or the site on the arm if not documented.

LEFT BLANK INTENTIONALLY

ROUTINE INFORMATION-UNDELIVERED

UNDELIVERED ADMISSION

Any admission of a woman to a facility during pregnancy in which a delivery does not take place.

ADMITTED FROM

Patient's location immediately prior to admission.

Found on the '*HOSPITAL ADMISSION FORM*'.

If patient is transferred from another hospital, record the standard 2- digit provincial code number for that facility found on pages 10-14.

If patient comes from home, code '0'.

If patient comes from the Emergency room of another facility without having been admitted to the facility, code '0', admitted from home.

GRAVIDA

The number of pregnancies, including the present pregnancy.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT FORM*' or the '*PHYSICIANS' ASSESSMENT FORM*'.

Code '**99**' for unknown.

PARA

The number of pregnancies, **excluding the present pregnancy**, which resulted in one or more infants weighing 500 grams or more at birth or 20 weeks gestation or greater gestational age regardless of whether such infants were stillborn, died after birth or lived.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT FORM*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '**99**' for unknown.

ABORTIONS

The number of pregnancies, **excluding the present pregnancy**, which resulted in a fetus weighing less than 500 grams or, when weight not known, less than 20 weeks gestation, regardless of whether the fetus was born alive.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT FORM*'.

Code '**99**' for unknown.

SPONTANEOUS ABORTIONS

Number of Spontaneous Abortions

Enter the number occurring within the documented category.

Found on the '*PRENATAL RECORD*'

Code '99' for unknown if it is not documented to indicate the number of the category.

THERAPEUTIC ABORTIONS

Number of Therapeutic Abortions

Enter the number occurring within the documented category.

Found on the 'PRENATAL RECORD'

Code '99' for unknown if it is not documented to indicate the number of the category.

UNSPECIFIED ABORTIONS

Number Unspecified as Spontaneous or Therapeutic Abortions

Found on the 'PRENATAL RECORD'

Code '99' for unknown if it is not documented to indicate the number of each category.

SCREENING TESTS

Found on '*LAB REPORTS*', '*DIAGNOSTIC IMAGING REPORTS*' or documented on the '*PRENATAL RECORD*'

Look for Lab/Diagnostic Imaging Reports showing that specified screening tests were done. If Lab/Diagnostic Imaging Reports are not available, review the Prenatal Record for evidence that the screening was done or not done. If there is no documentation indicate Unknown.

Group B Strep Screening

Y = Yes, done

N = Not done

U = Unknown

Nuchal Translucency Screening

Y = Yes, done

N = Not done

U = Unknown

* Nuchal Translucency is an ultrasound review done between 10 and 14 weeks gestation only and reported as nuchal translucency. Do not capture as Yes if noted as nuchal fold or nuchal thickness

HIV Testing

Y = Yes, done

D = Declined

U = Unknown

N = Not done

Maternal Serum

Y = Yes, done

D = Declined

U = Unknown

N= Not done

Capture as Yes if only one of the two tests/screens have been completed.

DISCHARGE DATE

Patient's discharge date from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Patient's discharge time from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'HHMM'.

"HH" is in range 0-23, "MM" is in range 0-59

If Discharge Time is not documented enter '9' in the field immediately following.

DISCHARGED TO

The immediate destination of patient on discharge.

Found in the '*NURSES' NOTES*' or the '*HOSPITAL ADMISSION FORM*' or the '*PHYSICIANS' ORDER SHEET*'.

Code using one of the standard 2- digit provincial codes for hospitals found on pages 10-14 or use one of the following codes:

If patient is discharged home, code 0.

Code '-9' for Death.

MATERNAL PRIMARY CAUSE OF DEATH

Found on '*DEATH CERTIFICATE*' or stated by the physician.

This field will grey out if mother lived.

Use **one** of the following options:

77777	Lived
OTHR	Other
PEMB	Pulmonary Embolus
PPHM	Postpartum Hemorrhage
STRK	Stroke

AUTOPSY

Completion of maternal autopsy.

Found on the "*DEATH CERTIFICATE*" or the '*AUTOPSY REPORT*'.

Code using one of the following:

LVD	Lived (not applicable)
Y	Died and autopsy done
N	Died but autopsy not done

ANTIBIOTIC THERAPY

Antibiotics administered during admission.

Found on the, '*MEDICATION SHEETS*'.

Enter **Y** if antibiotics administered. If no antibiotics administered, leave **blank**.

Code **Y** if antibiotic is given during the admission, even if it is for a non-pregnancy related condition.

If the antibiotic therapy was started before the admission and is still being taken during the admission, code the time and date started within 10 days of admission if documented. If not, code the first documented dosage after admission.

ANTIBIOTIC DATE

Date antibiotic therapy first given.

Found on '*MEDICATION SHEETS*'.

Use the following format: 'YYYYMMDD'.

Record the date of the first antibiotic therapy given to the mother during the hospital stay.

If date of first antibiotic therapy is not documented, leave date field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the date of the start of the antibiotic before admission, if documented. If the mother was on antibiotics prior to admission and the date is not documented, record unknown.

ANTIBIOTIC TIME

Time antibiotic therapy first given.

Found on '*MEDICATION SHEETS*'

Use the following format:'HHMM'.

'HH' is in range 0-23, 'MM' is in range 0-59.

Record the time of the first antibiotic therapy given to the mother during the hospital stay.

If time of first antibiotic therapy is not documented, leave time field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the time of the start of the antibiotic before admission ,if documented. If the mother was on antibiotics prior to admission and the time is not documented, record unknown.

PATIENT'S PROCESS STATUS

Indicates the coding status of undelivered routine information.

Code using one of the following:

- 2 Coding of chart in process. *The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 Coding of undelivered information completed.

Once the case is saved (status 4 or 5) the data can be viewed, but not changed. Status 4 indicates that the data is ready to be transferred, status 5 indicates that data has been transferred.

Once data has been frozen (status 4 or 5), requests for any necessary changes or corrections must be sent to the Health Information Coordinator at RCP.

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ROUTINE INFORMATION - POSTPARTUM ADMISSION

POSTPARTUM ADMISSIONS

Any admission of a woman up to 6 weeks postpartum.

Also include any admission beyond 6 weeks from delivery if the reason for the admission is stated as related to or caused by the pregnancy and or delivery.

NOTE: If a mother is admitted after an emergency birth which occurred in a hospital not providing maternity services or delivery at home, whether planned or unplanned and the mother and baby were transferred to another facility, the hospital receiving the transfer is requested to code the case as a 'DELIVERED ADMISSION' and not a postpartum admission.

ADMITTED FROM

Patient's location immediately prior to admission.

Found on the '*HOSPITAL ADMISSION FORM*'.

If patient is transferred from another hospital, record the standard 2- digit provincial code number for that facility found on pages 10-14.

If patient comes from home, code '0'.

If a patient comes from the Emergency Room of another facility without having been admitted to the facility, code '0', admitted from home.

GRAVIDA

The number of pregnancies, including the present pregnancy.

Found on the '*PHYSICIANS' ASSESSMENT FORM*' or '*PRENATAL RECORD*'

Code '**99**' for unknown.

PARA

The number of pregnancies, **including** the present pregnancy, which resulted in one or more infants weighing 500 grams or more at birth or 20 weeks gestation or greater gestational age regardless of whether such infants were stillborn, died after birth or lived.

Found on the '*PHYSICIANS' ASSESSMENT FORM*' or '*PRENATAL RECORD*'

Code '**99**' for unknown.

ABORTIONS

The number of pregnancies, **excluding** the present pregnancy, which resulted in a fetus weighing less than 500 grams or, when weight not known, less than 20 weeks gestation, regardless of whether the fetus was born alive.

Found on the '*PHYSICIANS ASSESSMENT FORM*' or '*PRENATAL RECORD*'

Code '**99**' for unknown.

SPONTANEOUS ABORTIONS

Number of Spontaneous Abortions

Enter the number occurring within the documented category.

Found on the 'PRENATAL RECORD'

Code '99' for unknown if it is not documented to indicate the number of the category.

THERAPEUTIC ABORTIONS

Number of Therapeutic Abortions

Enter the number occurring within the documented category.

Found on the 'PRENATAL RECORD'

Code '99' for unknown if it is not documented to indicate the number of the category.

UNSPECIFIED ABORTIONS

Number Unspecified as Spontaneous or Therapeutic Abortions

Found on the 'PRENATAL RECORD'

Code '99' for unknown if it is not documented to indicate the number of each category.

DISCHARGE DATE

Patient's discharge date from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Patient's discharge time from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'HHMM'.

"HH" is in range 0-23, "MM" is in range 0-59.

If discharge time is not documented enter '9' in the field immediately following.

DISCHARGED TO

The immediate destination of patient on discharge.

Found in the '*NURSES' NOTES*' or the '*HOSPITAL ADMISSION FORM*' or the '*PHYSICIANS' ORDER SHEET*'.

Code using one of the standard 2- digit provincial codes for hospitals found on pages 10-14 or use one of the following codes:

If patient is discharged home, code 0.

-9 *Maternal Death.*

0 home

MATERNAL PRIMARY CAUSE OF DEATH

Found on '*DEATH CERTIFICATE*' or stated by the physician.

This field will grey out if mother lived.

Use **one** of the following options:

77777	Lived
OTHR	Other
PEMB	Pulmonary Embolus
PPHM	Postpartum Hemorrhage
STRK	Stroke

AUTOPSY

Completion of maternal autopsy.

Found on the "*DEATH CERTIFICATE*" or the '*AUTOPSY REPORT*'.

Code using one of the following:

LVD	Lived (not applicable)
Y	Died and autopsy done
N	Died but autopsy not done

ANTIBIOTIC THERAPY

Antibiotics administered during admission.

Found on the '*MEDICATION SHEETS*'.

Enter **Y** if antibiotics administered. If no antibiotics administered, leave **blank**.

Code Y if antibiotic is given during the admission, even if it is for a non-pregnancy related condition.

If the antibiotic therapy was started before the admission and is still being taken during the admission, code the time and date started within 10 days of admission if documented. If not, code the first documented dosage after admission.

ANTIBIOTIC DATE

Date antibiotic therapy first given.

Found on '*MEDICATION SHEETS*'.

Use the following format: 'YYYYMMDD'.

Record the date of the first antibiotic therapy given to the mother during the hospital stay.

If date of first antibiotic therapy is not documented, leave date field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the date of the start of the antibiotic before admission, if documented. If the mother was on antibiotics prior to admission and the date not documented, record unknown.

ANTIBIOTIC TIME

Time antibiotic therapy first given.

Found on '*MEDICATION SHEETS*'.

Use the following format: 'HHMM'.

'HH' is in range 0-23, 'MM' is in range 0-59.

Record the time of the first antibiotic therapy given to the mother during the hospital stay.

If time of first antibiotic therapy is not documented, leave time field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the time of the start of the antibiotic before admission, if documented. If the mother was on antibiotics prior to admission and the time not documented, record unknown.

PROCESS STATUS

Indicates the coding status of undelivered routine information.

Code using one of the following:

- 2 Coding of chart in process. *The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 Coding of undelivered information completed.

Once the case is frozen (status 4 or 5) the data can be viewed, but not changed. Status 4 indicates that the data is ready to be transferred, status 5 indicates that the data has been transferred.

Once data has been frozen (status 4 or 5), requests for any necessary changes or corrections must be sent to the Health Information Coordinator at RCP.

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ROUTINE INFORMATION - NEONATAL ADMISSIONS

NEONATAL ADMISSIONS

- 1) Any infant with a birth weight of 500 grams or more, or a gestational age at birth of 20 or more completed weeks admitted or readmitted to hospital up to 27 days, 23 hours 59 minutes after birth.
- 2) Any infant transferred between hospitals who had not been discharged home from hospital.
- 3) Any admission to the Special Care Nursery.

BIRTH ORDER

Infant's order of birth

Found on the 'BIRTH RECORD' or the '*OPERATIVE REPORT*'.

Use one of the following codes:

- 1 Singleton, or first born of multiples.
- 2 Second born of multiples.
- 3 Third born of multiples.
- 4 Fourth born of multiples.
- 5 Fifth born of multiples.

ADMITTED FROM

Infant's location immediately prior to admission.

Found on the '*HOSPITAL ADMISSION FORM*'

If patient is transferred from another hospital, record the standard 2-digit provincial code number for that facility found on pages 10-14.

If a patient comes from the Emergency Room of another facility without having been admitted to the facility, code '0', admitted from home.

If patient comes from home, code '0'

BIRTH HOSPITAL

Infant's hospital of birth.

Found on the '*HOSPITAL ADMISSION FORM*' or the '*NURSES NOTES*'.

Code using one of the standard 2-digit provincial codes for hospitals found on pages 10-14.

SCN

Infant admitted to the Special Care Nursery or Premature Nursery; or infants requiring special care in normal nursery where premature nursery not available.

Found in the '*PROGRESS NOTES*'.

Code using one of the following:

Y Yes
N No

If 'Y' is entered, the screen SCN dates will pop up. Enter the admit and discharge dates to and from the Special Care Nursery.

If there is more than one admission and discharge to the Special Care Nursery during the same admission, enter the dates of the second admission in the next row. Continue until all admissions to Special Care Nursery are recorded.

OUTCOME

Outcome of infant at time of discharge

Found on the '*INFANT'S PROGRESS NOTES*'.

Code using one of the following:

- LVD Infant lived to be discharged from hospital.
- NND Liveborn infant who died before being discharged home from hospital.

BREASTFEEDING

Record one of the following to indicate the method of feeding during the hospital stay.

Found in the '*NURSES' NOTES*' or the '*PHYSICIAN NEWBORN ADMISSION FORM*' or the '*DISCHARGE FORM*'.

Code using one of the following:

- E Breast milk was exclusively given, breast milk, or expressed breast milk (EBM) during the hospital stay.

Cannot be given any food or liquid other than breast milk. Exception: May be given undiluted drops of syrups consisting of vitamins, mineral supplements, or medicines. Breast milk may be given by the mother, health care provider or family member/supporter.

If the baby was given breast milk and water or glucose water record as breast milk and formula

- N Baby was not given any breast milk or expressed breast milk during hospital stay
- S Baby was given both breast milk and other supplements, e.g formula, water, glucose water during hospital stay
- 9 There is no documentation as to how the baby was fed during the hospital stay

DISCHARGE DATE

Patient's discharge date from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Patient's discharge time from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'HHMM'.

"HH" is in range 0-23, "MM" is in range 0-59.

If Discharge Time is not documented enter '9' in the field immediately following.

DISCHARGED TO

The immediate destination of patient on discharge.

Found in the '*NURSES*' *NOTES*' or the '*HOSPITAL ADMISSION FORM*' or the '*PHYSICIANS*' *ORDER SHEET*'.

Code using one of the standard 2 -digit provincial codes for hospitals found on pages 10-14 or use one of the following codes:

If patient is discharged home, code 0.

-9 death.
0 home

AUTOPSY

Completion of infant autopsy.

Found on the '*NEWBORN CODING SHEET*' or the '*AUTOPSY REPORT*'.

Code using one of the following:

LVD Lived (e.g., not applicable)
Y Died and autopsy done
N Died but autopsy not done

PRIMARY CAUSE OF DEATH

Found on the '*AUTOPSY REPORT*' or stated by the physician.

Use **one** of the following codes:

7777 Infante lived
ABRP Abruptio placenta
ANEC Acute necrotizing enterocolitis
OAIR Airway failure
AMNO Amniocentesis
ANAL Analgesia or anaesthesia
ASPN Aspiration
CPDP Chronic pulmonary disease
COTR Complications of treatment
ANOM Congenital anomaly
CRLK Cord loops and/or knots
CDOT Cord, miscellaneous
CORP Cord prolapse
DBRN Degenerative brain disease
DUCT Ductus syndrome of prematurity
EXTX Exchange transfusion
FETH Fetal hemorrhage
FMAL Fetal malnutrition
HMDD Hyaline membrane disease
HYDR Idiopathic hydrops
IBOM Inborn errors of metabolism
INFT Infection

PRIMARY CAUSE OF DEATH
(con't)

IVTF	Intravascular transfusion
ISOM	Isoimmunization
KERN	Kernicterus
MALP	Malpresentation
DIAB	Maternal diabetes
SHOC	Maternal shock
MUSF	Multi-system failure
MINF	Myocardial infarction
NEOP	Neoplasia
TTTX	Twin-to-twin transfusion (Parabiotic syndrome)
PPFC	Persistent fetal circulation
PLPV	Placenta previa
AIRL	Pneumothorax pneumomediastinum and/or pneumopericardium
PIVH	Primary intraventricular hemorrhage
PPHN	Primary pulmonary hypertension
PULH	Primary pulmonary hemorrhage
RUPU	Ruptured uterus
SIDS	Sudden Infant death syndrome
THAB	Therapeutic abortions
TOXM	Toxemia
TRAS	Tracheal stenosis
TRAU	Trauma (obstetrical)
UNEX	Unexplained
UXPA	Unexplained peripartum asphyxia
VOLV	Acquired volvulus

DATE OF DEATH

Date of infant's death.

Found in the '*NURES*' *NOTES*' or the '*NEWBORN CODING SHEET*'.

Use the following format: 'YYYYMMDD'.

If date of death is unknown, enter '9' in the field immediately following.

TIME OF DEATH

Time of infant's death.
Found in the '*NURSES' NOTES*', or the '*NEWBORN CODING SHEET*'.

Use the following format: 'HHMM'.

'HH' is in the range 0-23, 'MM' is in range 0-59.

If time of death is unknown code '9' in the field immediately following.

FETAL MALNUTRITION/SOFT TISSUE WASTING

Fetal malnutrition or soft tissue wasting.

Found in '*DISCHARGE SUMMARY*' or '*NEONATOLOGIST'S LISTING*'

Choose one of the following:

- 1 Moderate Wasting
- 2 Severe Wasting

TWIN TYPE

Found on '*DISCHARGE SUMMARY*' or '*NEONATOLOGIST'S LISTING*'

Choose one from the following list:

- 1 Monoamniotic (one amniotic sac)
- 2 Monochorionic, diamniotic
- 3 Dichorionic, dissimilar sexes or blood groups
- 4 Dichorionic, similar sexes and blood groups
- 5 Dichorionic, similar sexes, blood groups undetermined
- 6 Undetermined
- 7 Siamese (Conjoined) twins

DEPRESSION AT BIRTH

Found on the '*BIRTH RECORD*', '*DISCHARGE SUMMARY*' or '*NEONATOLOGIST'S LISTING*'

Depression at birth, requiring intermittent positive pressure breathing. If both mask and tube are used from resuscitation, code as resuscitation by tube. Code the duration as the sum of both the mask and tube resuscitation. Or if masked and stopped and restarted again, code combined time of mask.

Code one of the following:

Bag and Mask

- | | |
|---|------------------|
| 1 | <1 minute |
| 2 | 1 to 3 minutes |
| 3 | >3 minutes |
| 4 | Unknown duration |

Endotracheal tube

- | | |
|---|------------------|
| 5 | <1 minute |
| 6 | 1 to 3 minute |
| 7 | >3 minutes |
| 8 | Unknown duration |

CPAP/T-Piece/Neopuff

- | | |
|----|------------------|
| 9 | <1 minute |
| 10 | 1 to 3 minute |
| 11 | >3 minutes |
| 12 | Unknown duration |

ELECTIVE NON-RESUSCITATION

Found on the '*DISCHARGE SUMMARY*' or '*NEONATOLOGIST'S LISTING*'

Choose from the following list:

- 1 Do not resuscitate order on chart
- 2 Withdrawal of ventilator care with do not resuscitate order on chart
- 3 Non-resuscitation in labour and delivery room

MATERNAL STEROID THERAPY

Found on the '*MEDICATION SHEET*' or on the '*PRENATAL RECORD*'

Code the earliest dose of the first course of treatment. In a fetal death, estimate the duration of therapy from the first dosage to time of delivery

Code one of the following:

Dexamethasone

- 1 <24 hours before delivery
- 2 24 to 48 hours before delivery
- 3 >48 hours but less than or equal to 7 days before delivery
- 4 _____ >7 days before delivery
- 5 Unknown when administered

Betamethasone (Celestone)

- 6 _____ <24 hours before delivery
- 7 _____ 24 to 48 hours before delivery
- 8 _____ >48 hours but less than or equal to 7 days before delivery
- 9 _____ >7 days before delivery
- 10 Unknown when administered

**RETINOPATHY OF
PREMATURITY**

Found on the '*DISCHARGE SUMMARY*'.

Code one of the following:

- | | | |
|---|---------|--------------------------------------|
| 1 | Stage 1 | Peripheral vascular
straightening |
| 2 | Stage 2 | Peripheral shunt well seen |
| 3 | Stage 3 | Vessels growing into vitreous |
| 4 | Stage 4 | Retinal detachment |

**CHROMOSOMAL
ABNORMALITIES**

Found on '*GENETICS REPORT*' or
'NEONATOLOGIST LISTING'

Code one chromosomal abnormality from the listing:

- 1 Aneuploidy
- 2 Chimerism
- 3 Mosaicism
- 4 Triploidy
- 5 Deletion
- 6 Duplication
- 7 Microdeletion
- 8 Monosomy
- 9 Ring
- 10 Tandem Repeat
- 11 Trisomy
- 12 Uniparental Disomy
- 13 Translocation

Please note that chromosome numbers are from 1 to 23 and X and Y.

If Aneuploidy, Chimerism or Triploidy are selected you DO NOT have to code the chromosome affected, the affected arm (p or q) or the site on the arm.

If Mosaicism, Deletion, Duplication, Microdeletion, Monosomy, Ring, Tandem Repeat, Trisomy or Uniparental Disomy are selected code also the affected chromosome. You DO NOT have to code the affected arm (p or q) or the site on the arm if not documented.

If Translocation is selected two chromosomes should be coded. You DO NOT have to code the affected arm (p or q) or the site on the arm if not documented

ADULT RCP CODES

MATERNAL ANTIBODY CONDITIONS DURING PREGNANCY

(R001)

(ANTIBODY CONDITIONS)

For use with: Delivered
Undelivered

Found on the 'RED CROSS SHEETS'
Choose as many as are indicated;

100	Anti-La
200	Anti-D (Rh)
300	Anti-Big C (Cw)
400	Anti-Big E
500	Anti-Big S
600	Anti-Dha (DUCH)
700	Anti-Fya (Duffy)
800	Anti-Kell (K1/K2)
900	Anti-Kidd (JKa)
1000	Anti-Little c
1100	Anti-Little e
1200	Anti-Little s
1300	Anti-Lutheran (Lua/Lub)
1400	Anti-Wright (Wra/Wrb)
1500	Antinuclear Antibody (ANA)
1600	Anti-Cardiolipin
1700	Anti-DNA Antibody
1800	Lupus Antibody (Lupus Anticoagulant)
1900	Anti-SSA (Ro)
2000	Anti-Phospholipid
2100	Factor V Leiden
2200	PL-A1 Platelet Antigen Negative

MATERNAL CARRIER STATES AND/OR CHRONIC INFECTION DURING PREGNANCY

(R002)

(CARRIER-STATE/CHRONIC
INFECTIONS)

For Use With: Delivered
Undelivered

Found on the 'PRENATAL RECORD' or
'DISCHARGE SUMMARY'.

Choose as many as are indicated;

100	Cytomegalovirus
200	Group B Strep
300	Herpes Simplex
400	HIV/Acquired Immune Deficiency Syndrome
600	Syphilis
700	Toxoplasmosis
800	Serum Hepatitis Carrier (Antigen positive; Hepatitis A)
900	Serum Hepatitis Carrier (Antigen positive; Hepatitis B)
1000	Serum Hepatitis Carrier (Antigen positive; Hepatitis C)
1100	Serum Hepatitis Carrier (Antigen positive; Hepatitis viral)

MATERNAL DRUG THERAPIES
FOR SPECIFIC CONDITIONS
OF PREGNANCY, DELIVERY
AND POSTPARTUM
(R003)

(DRUGS FOR CONDITIONS
 PREG/PP)

For Use With: Delivered
 Undelivered
 Postpartum

Found on the 'PRENATAL RECORD'.

Choose as many as are indicated;

- 100 Adalat (nifedipine) for premature labour
- 300 Atosiban for premature labour
- 400 Hemabate for Postpartum Hemorrhage
- 500 Indocid (Indomethacin) for premature labour
- 600 Indocid (Indomethacin) for tx of Polyhydramnios
- 700 Magnesium sulfate therapy (MgSO₄)(for hypertension or seizures, e.g. Eclampsia prophylaxis or treatment).
- 800 Magnesium Sulfate (MgSO₄) for premature labour
- 900 Pentaspan for Postpartum Hemorrhage
- 1000 Terbutaline (Bricanyl) for premature labour
- 1100 Ventolin for premature labour
- 1200 Other Drugs for Specific Pregnancy, Delivery or Postpartum conditions
- 1300 Ergot for Postpartum Hemorrhage
- 1400 Misoprostil for Postpartum Hemorrhage

MATERNAL DRUG THERAPY
DURING
PREGNANCY/POSTPARTUM
PERIOD
(R004)

(DRUG THERAPY IN PREG/PP)

For Use With: Delivered
 Undelivered
 Postpartum

Found on the 'PRENATAL RECORD'.

Choose as many as are indicated;

Code if noted taken before found out was pregnant

- 100 Anti-coagulation therapy
- 200 Anti-Depressives
- 300 Anti-epileptics
- 400 Anti-hypertensives
- 500 Chronic Narcotic Use (Not Abuse, when indicated for medical problems, e.g. Back pain)
- 600 Lithium
- 700 Methadone (Therapy, not abuse)
- 800 Other Psychiatric Medications
- 900 Other Specified
- 1000 ASA Therapy (Low dose aspirin therapy for Lupus and/or any other autoimmune conditions)
- 1100 Insulin therapy
- 1200 Thyroid Medication
- 1300 Anti-Anxiety Medication
- 1400 Nicotine Replacement Therapy

**MATERNAL DRUG AND
CHEMICAL ABUSE DURING
PREGNANCY**

(R005)

(DRUGS-ABUSE IN PREG)

For Use with: Delivered
Undelivered

Found on the '*PRENATAL RECORD*'.

Choose as many as are indicated;

Code if noted used before found out was pregnant.

200	Ativan
300	Cocaine/Crack
400	Codeine
500	Demerol
600	Dilaudid
700	Hash
800	Heroin
900	Marijuana
1000	Methadone
1100	Morphine
1200	Prescription Medication Abuse
1300	Solvents
1400	Valium
1500	Other Specified Abuse
1600	OxyContin
1700	Ecstasy
1800	Alcohol Abuse- Binge
1900	Alcohol Abuse - Chronic
2000	Alcohol Abuse - unknown Binge or Chronic

MATERNAL/FETAL
DIAGNOSTIC AND
THERAPEUTIC PROCEDURES
(R006)

Found on the '*PRENATAL RECORD*'.

Choose as many as are indicated;

For Use With: Delivered
Undelivered

- 100 Amniocentesis for Genetic testing
- 200 Amniocentesis for Isoimmunization
- 300 Amniocentesis for Lung Maturity
- 400 Amnioreduction (Polyhydramios, Twin to Twin Transfusion)
- 500 Amnioinfusion during labour
- 600 Chorionic Villi Sampling
- 700 Cordocentesis
- 801 One (1) Fetal Blood transfusion
- 802 Two (2) Fetal Blood transfusions
- 803 Three (3) Fetal Blood transfusions
- 804 Four (4) Fetal Blood transfusions
- 805 Five (5) Fetal Blood transfusions
- 806 Six (6) Fetal Blood transfusions
- 807 Seven (7) Fetal Blood transfusions
- 808 Eight (8) Fetal Blood transfusions
- 809 Nine (9) Fetal Blood transfusions
- 810 Ten (10) Fetal Blood transfusions
- 900 Fetal Drainage (eg. Thoracentesis, hydrocephalus, Urinary)
- 1000 Fetal Reduction
- 1100 Feto/placental laser
- 1200 Fetal Stent Placement
- 1300 Forceps rotation during delivery
- 1400 Manual rotation during delivery
- 1500 Vacuum rotation during delivery
- 1600 Removal of device, cervix of cerclage suture
- 1700 External Version
- 1800 Internal Version

**ANAESTHESIA DURING
LABOUR AND DELIVERY
(R010)**

For Use With: Delivered

Found on the '*ANAESTHESIA RECORD*'
Choose as many as were administered during labour and
delivery.

- 100 Entonox (Nitronox)
- 200 Epidural - Single Administration
- 300 Epidural - Continuous Catheter With Intermittent Drug
Administration
- 400 Epidural - Continuous Infusion of Drug (CIEA)
- 500 Epidural - Patient Controlled Epidural Analgesia
(PCEA)
- 600 General Anaesthesia
- 700 Patient Controlled Intravenous Analgesia
- 800 Pudendal
- 900 Spinal Anaesthesia
- 1000 Spinal/Epidural double needle
- 1100 Other specified Anaesthesia (eg. Acupuncture,
Hypnotism Neuroleptic)

**ANAESTHESIA DURING
LABOUR ONLY
(R011)**

For Use With: Delivered

Found on the '*ANAESTHESIA RECORD*'.
Choose as many as were administered.

- 100 Entonox (Nitronox)
- 200 Epidural - Single Administration
- 300 Epidural - Continuous Catheter With Intermittent Drug
Administration
- 400 Epidural - Continuous Infusion of Drug (CIEA)
- 500 Epidural - Patient Controlled Epidural Analgesia
(PCEA)
- 600 General Anaesthesia
- 700 Patient Controlled Intravenous Analgesia
- 800 Pudendal
- 900 Spinal Anaesthesia
- 1000 Spinal/Epidural double needle
- 1100 Other specified Anaesthesia (eg. Acupuncture,
Hypnotism, Neuroleptic)

ANAESTHESIA DURING
DELIVERY ONLY
(R012)

Found on the '*ANAESTHESIA RECORD*'.

Choose as many as were administered.

For Use With: Delivered

- 100 Entonox (Nitronox)
- 200 Epidural - Single Administration
- 300 Epidural - Continuous Catheter With Intermittent Drug Administration
- 400 Epidural - Continuous Infusion of Drug (CIEA)
- 500 Epidural - Patient Controlled Epidural Analgesia (PCEA)
- 600 General Anaesthesia
- 700 Patient Controlled Intravenous Analgesia
- 800 Pudendal
- 900 Spinal Anaesthesia
- 1000 Spinal/Epidural double needle
- 1100 Other specified Anaesthesia (eg. Acupuncture, Hypnotism, Neuroleptic)

COMPLICATIONS OF
ANESTHESIA
(R013)

Found on the 'ANAESTHESIA RECORD' or 'DISCHARGE SUMMARY'

Choose from the following.

For use with :	Delivered	100	Blood Patching
	Undelivered	200	Toxic Intravenous Injection (systemic reaction)
	Postpartum	300	Epi-catheter Intravenous
		400	Accidental Dural Tap
		500	Total Spinal Anesthesia
		600	Prolonged Epidural Block
		700	High Epidural/Subdural Block
		800	Foot Drop
		900	Epidural Hematoma
		1000	Epidural Abscess
		1100	Spinal Cord Lesion
		1200	Aspiration Pneumonitis
		1300	Cardiac Arrest
		1400	Post-dural Puncture Headache
		1500	Paraesthesia
		1600	Hypotension
		1700	Back Pain
		1800	Failed Intubation for General Anesthetic

**OTHER OBSTETRICAL
CONDITIONS AFFECTING
PREGNANCY
(R014)**

Found on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY*'

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Pruritic urticarial papules and plaques of pregnancy
- 200 Impetigo herpetiformis
- 300 Dermatitis herpetiformis
- 400 Separation of symphysis pubis
- 500 Gestational [pregnancy-induced] hypertension without significant proteinuria. Includes: Gestational hypertension NOS, Mild pre-eclampsia
- 600 Gestational [pregnancy-induced] hypertension with significant proteinuria. Includes: HELLP (syndrome) (hemolysis/elevated liver enzymes/low platelets)
- 700 Pre-existing hypertension complicating pregnancy, childbirth and the puerperium
- 800 Pre-existing hypertensive disorder with superimposed proteinuria
- 900 Pre-existing diabetes mellitus, Type 1
- 1000 Pre-existing diabetes mellitus, Type 2
- 1100 Pre-existing diabetes mellitus of other specified type present when became pregnant during this pregnancy
- 1200 Pre-existing diabetes mellitus, of unspecified type present when became pregnant during this pregnancy
- 1300 Diabetes mellitus arising in pregnancy. Includes: Gestational diabetes
- 1400 Diabetes mellitus in pregnancy, unspecified
- 1500 Anemia in Pregnancy (Hb < 10% in pregnancy)
- 1600 Febrile Morbidity (38 degrees or more on 2 or more occasions at least 4 hours, in any 48 hour period, excluding the first 24 hours after delivery, regardless of cause.)
- 1700 Maternal Fever >38 degrees

**GASTRO- INTESTINAL
DISEASES**

Found on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY*'

**(CODE IF CONDITION IS OR
WAS PRESENT DURING THE
PREGNANCY)**
(R015)

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Cholelithiasis
- 200 Ulcerative colitis/proctitis
- 300 Crohn's disease
- 400 Irritable Bowel Syndrome
- 500 Pancreatitis, Acute and Chronic
- 600 Reflux Gastritis
- 700 Ulcers(all types)

PSYCHIATRIC ILLNESS

Found on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY*'

**(CODE IF CONDITION IS OR
WAS PRESENT DURING THE
PREGNANCY)**
(R016)

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Anxiety disorders
- 200 Depression
- 300 Eating disorders (e.g. anorexia nervosi, bulimia nervosa)
- 400 Manic-Depression
- 500 Schizophrenia
- 600 Other

NEUROLOGICAL ILLNESS

Found on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY*'

**(CODE IF THE CONDITION IS
OR WAS PRESENT DURING
THE CURRENT PREGNANCY)
(R017)**

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Bell's palsy
- 200 Cerebral palsy
- 300 Epilepsy
- 400 Intracerebral hemorrhage
- 500 Muscular dystrophy
- 600 Myasthenia gravis
- 700 Multiple sclerosis
- 800 Presence of Harrington Rod
- 900 Subarachnoid hemorrhage
- 1000 Seizure
- 1100 Tuberos sclerosi
- 1200 Thoracic outlet syndrome
- 1300 Other

HEART DISEASEFound on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY*'**(CODE IF THE CONDITION IS OR WAS PRESENT DURING CURRENT PREGNANCY)**
(R018)

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Arrhythmia
- 200 Congenital heart disease
- 300 Cardiac Arrest
- 400 Coronary artery disease
- 500 Endocarditis
- 600 History of heart disease or surgery
- 700 Myocardial infarction
- 800 Prolapsed mitral valve
- 900 Cardiomyopathy
- 1000 Myocarditis
- 1100 Pulmonary hypertension
- 1200 Rheumatic heart disease
- 1300 Valve prosthesis
- 1400 Wolff Parkinson's White Syndrome
- 1500 Other acquired cardiac diseases
- 1600 Thromboembolic Disease

ENDOCRINE DISEASEFound on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY*'**(CODE IF THE CONITION IS OR WAS PRESENT DURING THE CURRENT PREGNANCY)**
(R019)

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Disorder of Adrenal Gland
- 200 Disorder of Ovary
- 300 Hashimoto's Thyroiditis
- 400 Hyperthyroidism with Goiter
- 500 Hyperthyroidism with Thyroid nodule
- 600 Hyperthyroidism with Goiter, nodular
- 700 Hyperthyroidism without Goiter
- 800 Hypothyroidism
- 900 Hyperparathyroidism
- 1000 Disorder of Hypothalamus
- 1100 Disorder of Pituitary gland

RENAL DISEASE

Found on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY*'

**(CODE IF THE CONDITION IS
OR WAS PRESENT DURING
THE CURRENT PREGNANCY)
(R020)**

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Acute pyelonephritis
- 200 Renal calculus
- 300 Chronic glomerulonephritis
- 400 Previous episode of acute pyelonephritis during current pregnancy
- 500 Hydronephrosis
- 600 Nephropathy
- 700 Nephrotic syndrome
- 800 Polycystic kidney disease
- 900 Chronic pyelonephritis
- 1000 Renal agenesis
- 1100 Renal transplant
- 1200 Chronic renal disease, type undetermined
- 1300 Urinary tract Infection

**NEOPLASM, INCLUDING
MALIGNANCIES**

Found on the '*PRENATAL RECORD*' or '*DISCHARGE
SUMMARY*'

**(CODE IF CONDITION IS OR
WAS PRESENT DURING THE
CURRENT PREGNANCY)
(R021)**

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Bowel
- 200 Breast
- 300 Cervix
- 400 Other
- 500 Ovary (Teratoma)
- 600 Thyroid
- 700 Vagina

BLOOD DYSCRASIAS

Found on the '*PRENATAL RECORD*' or '*DISCHARGE
SUMMARY*'

**(CODE IF THE CONDITION IS
OR WAS PRESENT DURING
THE CURRENT PREGNANCY/
POSTPARTUM PERIOD)
(R022)**

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Hemolytic anemia
- 200 Dysfibrinogenemia
- 300 Factor 12 deficiency
- 400 Familial hypofibrinogenemia
- 500 Factor VIII deficiency
- 600 G6PD deficiency
- 700 Idiopathic Hypoplastic Anemia
- 800 Idiopathic thrombocytopenic purpura (ITP)
- 900 Sickle cell anemia
- 1000 Thalassemia
- 1100 Von Willebrand's disease
- 1200 Thrombotic Thrombocytopenia purpura(TTP)
- 1300 Thrombocytopenia

PULMONARY DISEASE

Found on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY*'

(CODE IF THE CONDITION IS OR WAS PRESENT DURING CURRENT PREGNANCY)
(R023)

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Asthma
- 200 Cystic fibrosis
- 300 Pulmonary edema
- 400 Other significant pulmonary diseases
- 500 Pneumonia, antepartum

OTHER NON-OBSTETRICAL DISEASES, NOT ELSEWHERE CLASSIFIABLE

Found on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY*'

(CODE IF THE CONDITION IS OR WAS PRESENT DURING THE CURRENT PREGNANCY)
(R024)

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Ankylosing spondylitis
- 200 Cholinesterase Deficiency
- 300 Family or personal history of Malignant Hyperthermia
- 400 Neurofibromatosis (Von Recklinghausen's Disease)
- 500 Porphyria
- 600 Maternal phenylketonuria
- 700 Rheumatoid arthritis/Psoriatic
- 800 Sarcoidosis
- 900 Scleroderma
- 1000 Scoliosis
- 1100 Sjogren's Syndrome
- 1200 Systemic lupus
- 1300 Scheurmann's Disease

PREVIOUS PREGNANCY
MATERNAL DISEASES
(R025)

Found on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY*'

Choose as many as documented

For use with: Delivered
Undelivered
Postpartum

- 100 Previous History of Personal Malignancy
- 200 Previously Sensitized Pregnancy
- 300 Hypertensive Disease In Previous Pregnancy
- 400 Previous Eclampsia
- 500 Previous Ectopic Pregnancy
- 600 Previous Molar Pregnancy
- 700 Previous Anemia
- 800 Previous Abruption Placenta
- 900 Previous Breech
- 1000 Previous Thromboembolic Disease
- 1100 Previous Gestational Diabetes
- 1200 Previous History of Infertility
- 1300 Previous Postpartum Depression

MATERNAL TRANSFUSIONS.
BLOOD AND OTHER
PRODUCTS
(R026)

Found on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY* or *Operative Report*'

Choose as many as documented

For use with:	Delivered	100	One Maternal Blood Transfusion
	Undelivered	200	Two Maternal Blood Transfusions
	Postpartum	300	Three Maternal Blood Transfusions
		400	Four Maternal Blood Transfusion
		500	Five Maternal Blood Transfusion
		600	Six Maternal Blood Transfusion
		700	Seven Maternal Blood Transfusions
		800	Eight Maternal Blood Transfusions
		900	Nine Maternal Blood Transfusions
		1000	Ten Maternal Blood Transfusions
		1100	More than 10 Maternal Blood Transfusions
		1200	Albumin Transfusion
		1300	Cryoprecipitate Transfusion
		1400	Fresh Frozen Plasma Transfusion
		1500	Gamma Globulin Transfusion
		1600	Plasma Exchange/Plasmapheresis Transfusion
		1700	Platelet Transfusion

REASON FOR MATERNAL
BLOOD TRANSFUSION
(R027)

Found on the '*PRENATAL RECORD*' or '*DISCHARGE SUMMARY* or *Operative Report*'

Choose as many as documented

For use with:	Delivered		
	Undelivered	100	Anemia in Pregnancy
	Postpartum	200	Antepartum Hemorrhage
		300	Intrapartum Hemorrhage
		400	Postpartum Hemorrhage
		500	Other

INFANT RCP CODES

PLACENTAL OR CORD ANOMALIES (R051)

Found in 'OBSTETRICIAN'S REPORT' or 'PLACENTAL PATHOLOGY REPORT'

Code all that are applicable.

100	Amnionodosum
200	Chorioamnionitis, marked or severe
300	Choroangioma of placenta
400	Circumvallate placenta
500	Funisitis
600	Funisitis, necrotizing
700	Funisitis, candidal
800	Hematoma of umbilical cord
900	Marginal insertion of cord/Batteldore
1000	Membranous placenta
1100	Placenta accreta
1200	Placenta Increta
1300	Placenta percreta
1400	Single umbilical artery
1500	True knot in cord
1600	Vasa previa
1700	Velamentous insertion of cord

**ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054)**

Found on the 'DISCHARGE SUMMARY' or 'NEONATOLOGIST LISTING' or 'CHROMOSOMAL REPORT'

Code all that are applicable;

- 100 Aarskog syndrome
- 200 Aase syndrome
- 300 Acardia
- 400 Accutane embryopathy
- 500 Achondrogenesis type Ia
- 600 Achondrogenesis type Ib
- 700 Achondrogenesis type II
- 800 Achondrogenesis-dysplasia congenita type II
- 900 Achondroplasia
- 1000 Acoustic neurofibromatosis
- 1100 Acrocallosal syndrome
- 1200 Acrocephalosyndactyly syndrome
- 1300 Acrodysostosis
- 1400 Acrofacial dysostosis syndrome
- 1500 Acromegaly
- 1600 Acromesomelic dwarfism (dysplasia)
- 1700 Acro-osteolysis syndrome (Artho-dento-osteo dysplasia)
- 1800 Adactyly
- 1900 Adams-Oliver syndrome
- 2000 Adenoma sebaceum
- 2100 Adrenal hyperplasia
- 2200 Adrenal hypoplasia
- 2300 Adrenoleukodystrophy
- 2400 Aec syndrome (Ankyloblepharon-ectodermal dysplasia-clefting syndrome)
- 2500 Agenesis of corpus callosum
- 2600 Aglossia-adactyly syndrome
- 2700 Aicardia syndrome
- 2800 Akinesia sequence
- 2900 Alagille syndrome
- 3000 Albright hereditary osteodystrophy
- 3100 Alopecia
- 3200 Aminopterin embryopathy
- 3300 Amnion rupture sequence
- 3400 Amyoplasia congenita disruptive sequence
- 3500 Anal atresia
- 3600 Anencephaly
- 3700 Aneurysm of the vein of Galen
- 3800 Angelman syndrome (Happy Puppet Syndrome)

ANOMALY/ METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

3900	Aniridia
4000	Aniridia-Wilm's tumor association
4100	Anodontia
4200	Anorectal malformation
4300	Antley-Bixler syndrome
4400	Apert syndrome
4500	Arachnodactyly
4600	Arachnoid cyst
4700	Argininaemia
4800	Argininosuccinic aciduria
4900	Arteriohepatic dysplasia
5000	Arteriovenous malformation of the lung
5100	Arthrogryposis, muscular
5200	Arthrogryposis, neurogenic
5300	Arthro-ophthalmopathy (Stickler Syndrome)
5400	Asphyxiating thoracic dystrophy
5500	Asplenia syndrome
5600	Ataxia - telangiectasia syndrome (Lovis-Bar Syndrome)
5700	Atelosteogenesis, type I (Chondrodysplasia, giant cell)
5800	Athyrotic hypothyroidism sequence
5900	Atr-x syndrome
6000	Baller Gerold syndrome
6100	Bannayan syndrome (Bannayan-Riley-Ruvalcaba syndrome)
6200	Bardet-Biedl syndrome
6300	Beals syndrome (Beals contractural arachnodactyly)
6400	Beckwith syndrome (Beckwith-Wiederman Syndrome)
6500	Berardinelli lipodystrophy syndrome
6600	Bicorunate uterus
6700	Bifid scrotum
6800	Bifid uvula
6900	Bladder exstrophy
7000	Blepharophimosis
7100	Bloch-sulzberger syndrome
7200	Bloom syndrome
7300	Blue sclera
7400	Body stalk anomaly
7500	Bor syndrome (Brachio-oto-renal syndrome)
7600	Börjeson-Forssman-Lehmann syndrome
7700	Brachmann-de Lange syndrome (Cornelia deLange syndrome)
7800	Brachydactyly
7900	Branchial sinus

ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

8000	Branchio-oculo-facial syndrome
8100	Breech deformation sequence
8200	Brushfield spots
8300	Buru-Baraister syndrome
8400	Caffey pseudo-hurler syndrome
8500	Campomelic dysplasia
8600	Camurati-Engelmann syndrome
8700	Capillary hemangioma
8800	Cardio-facio-cutaneous syndrome (CFC)
8900	Cardiomyopathy, congenital
9000	Carnitine deficiency
9100	Carpenter syndrome
9200	Cartilage-hair hypoplasia syndrome
9300	Catel-Manzke syndrome
9400	Cat-eye syndrome
9500	Caudal dysplasia sequence
9600	Caudal regression syndrome
9700	Cavernous hemangioma
9800	Cebocephaly
9900	Cephalopolysyndactyly syndrome (Greig Syndrome)
10000	Cerebellar calcification
10100	Cerebellar hypoplasia
10200	Cerebral calcification
10300	Cerebral gigantism syndrome
10400	Cerebro-costo-mandibular syndrome
10500	Cerebro-oculo facio-skeletal (cofs) syndrome
10600	Cerevico-oculo-acoustic syndrome
10700	Charcot-Marie-Tooth syndrome
10800	Charge syndrome
10900	Child Syndrome (Congenital hemidysplasia)
11000	Choanal atresia
11100	Chondrodysplasia punctata (Condracli-Hünemann Syndrome)
11200	Chondrodystrophica myotonia (Schwartz-Jampel Syndrome)
11300	Chondroectodermal dysplasia (Ellis-van Creveld syndrome)
11400	Chondromatosis
11500	Citrullinaemia
11600	Cleft face
11700	Cleft lip, unilateral
11800	Cleft lip, bilateral
11900	Cleft tongue
12000	Cleft palate

ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

12100	Cleidocranial dysostosis
12200	Clinodactyly
12300	Cloacal exstrophy
12400	Clouston syndrome
12500	Cloverleaf skull
12600	Clubfoot
12700	Cockayne syndrome
12800	Coffin-Lowry syndrome
12900	Coffin-Siris syndrome
13000	Cohen syndrome
13100	Coloboma of iris
13200	Colon, malrotation
13300	Congenital adrenal hyperplasia
13400	Congenital hypothyroidism
13500	Congenital microgastria-limb reduction complex
13600	Conjoined twins
13700	Cortical hypoplasia
13800	Costello syndrome
13900	Coumarin embryology effects
14000	Craniofacial dysostosis (Crouzon Syndrome)
14100	Craniofrontonasal dysplasia
14200	Cranio metaphyseal dysplasia
14300	Craniosynostosis
14400	Craniosynostosis, coronal
14500	Craniosynostosis, frontal
14600	Craniosynostosis, Kleeblattschadel
14700	Craniosynostosis, lambdoid
14800	Craniosynostosis, sagittal
14900	Craniosynostosis, trigonocephaly
15000	Cri du chat syndrome
15100	Cryptophthalmos anomaly (Fraser Syndrome)
15200	Cryptorchidism
15300	Cubitus valgus
15400	Cutis aplasia
15500	Cutis hyperelastica
15600	Cutis laxa
15700	Cutis marmorata
15800	Cyclopia
15900	Cyclops
16000	Cystathionuria
16100	Cystic adenomatoid malformation of the lung
16200	Cytomegalic inclusion disease
16300	Dandy-walker syndrome
16400	Darwinian tubercle

ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

16500	Dental cyst
16600	Deprivation syndrome
16700	Dermal ridge, aberrant
16800	Desanctis-Cacchione syndrome
16900	Diabetes insipidus
17000	Diabetes mellitus
17100	Diaphragmatic hernia
17200	Diaphyseal aclasis
17300	Diastrophic dysplasia
17400	Diastrophic nanism
17500	DiGeorge syndrome
17600	Dilantin embryopathy
17700	Dimple, sacral
17800	Distal arthogyrposis syndrome
17900	Distichiasis-lymphedema syndrome
18000	Donohue syndrome (Leprechaunism Syndrome)
18100	Down syndrome
18200	Dubowitz syndrome
18300	Duodenal atresia
18400	Dwarfism, acromesomelic
18500	Dwarfism, metatrophic
18600	Dyggve-Melchoir-Clausen syndrome
18700	Dysencephalia splanchnocystica (Meckel-Gruber Syndrome)
18800	Dyskeratosis congenita syndrome
18900	Dystrophia myotonica, Steinert (Myotonic dystrophy)
19000	Early urethral obstruction syndrome
19100	Ectodermal dysplasia
19200	Ectrodactyly, tibial
19300	Ectrodactyly-ectodermal dysplasia-clefting syndrome (EEC)
19400	Eczema
19500	Ehlers-danlos syndrome
19600	Elbow dysplasia
19700	Enamel hypoplasia
19800	Encephalocele
19900	Encephalocraniocutaneous lipomatosis
20000	Endocrine neoplasia,multiple, type 2
20100	Epidermal nevus syndrome
20200	Epiphyseal calcification
20300	Epiphyseal dysplasia, multiple
20400	Equinovarus deformity
20500	Escobar syndrome (Multiple pterygium dysplasia)
20600	Esophageal atresia

ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

20700	Exomphalos
20800	External chorionmatosis
20900	Fabry's disease
21000	Falx calcification
21100	Familial blepharophimosis syndrome
21200	Familial short stature
21300	Fanconi syndrome
21400	Fetal alcohol syndrome (FAS)
21500	Femoral hypoplasia-unusual facies syndrome
21600	Fetal face syndrome (Robinow Syndrome)
21700	Fg syndrome
21800	Fibrochondrogenesis
21900	Fibrodysplasia ossificans progressiva syndrome
22000	First and second brachial arch syndrome
22100	Floating-habour syndrome
22200	Fragile x syndrome (Martin-Bell Syndrome)
22300	Franceschetti-Klein syndrome (Treacher-Collins Syndrome)
22400	Freeman-Sheldon syndrome (Whistling Face Syndrome)
22500	Frenula, absent
22600	Frontal bossing
22700	Frontometaphyseal dysplasia
22800	Frontonasal dysplasia sequence
22900	Fryns syndrome
23000	Galactosemia
23100	Gastroschisis
23200	Geleophysic dysplasia
23300	Gilles telencephalic leucoencephalopathy
23400	Glaucoma
23500	Glossopalatine ankylosis syndrome
23600	B-glucosidase deficiency
23700	Glycogen storage disease
23800	Goiter
23900	Goldenhar syndrome
24000	Goltz syndrome
24100	Gonadal dysgenesis
24200	Gorlin syndrome (Nevoid basal cell carcinoma)
24300	Grebe syndrome
24400	Hallerman-streiff syndrome
24500	Hamartosis
24600	Hemangioma
24700	Hemangioma, capillary
24800	Hemangioma, cavernous

ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

24900	Hemangioma, port-wine
25000	Hecht syndrome
25100	Hemifacial microsomia
25200	Hemochromatosis
25300	Hemorrhagic telangiectasia, hereditary
25400	Hereditary arthro-ophthalmopathy
25500	Hereditary osteo-onchodysplasia (Nail patella syndrome)
25600	Hirshsprung aganglionosis
25700	Holoprosencephaly
25800	Holt-oram syndrome
25900	Homocystinuria syndrome
26000	Homozygous Leri-Weill syndrome
26100	Hunter syndrome
26200	Hurler syndrome
26300	Hurler-Scheie syndrome
26400	Hutchinson-Gilford syndrome (Progeria Syndrome)
26500	Hydantoin embryology
26600	Hydatidiform placenta
26700	Hydranencephaly
26800	Hydrocele
26900	Hydrocephalus
27000	Hydrops fetalis
27100	Hyperammonaemia
27200	Hypochondrogenesis
27300	Hypochondroplasia
27400	Hypodactyly, hypoglossal
27500	Hypodontia
27600	Hypogenitalism
27700	Hypoglossia-hypodactyly syndrome
27800	Hypogonadism
27900	Hypohidrotic ectodermal dysplasia (Rapp-Hodgkin ectoderma)
28000	Hypomelanosis of ito
28100	Hypomellia-hypotrichosis-facial hemangioma syndrome
28200	Hypospadias
28300	Hypospadias, glandular (first degree)
28400	Hypospadias, coronal (second degree)
28500	Hypospadias, shaft (third degree)
28600	Hypospadias, perineal (fourth degree)
28700	Hypotrichosis
28800	Ichthyosiform erythroderma (Senter-Kid Syndrome)
28900	Immune deficiency

ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

29000	Immunoglobulin deficiency
29100	Imperforate anus
29200	Iniencephaly
29300	Intestinal atresia
29400	Intestinal atresia, anal
29500	Intestinal atresia, colonic
29600	Intestinal atresia, duodenal
29700	Intestinal atresia, ileal
29800	Intestinal atresia, jejunal
29900	Intestinal stenosis
30000	Intestinal stenosis, anal
30100	Intestinal stenosis, colonic
30200	Intestinal stenosis, duodenal
30300	Intestinal stenosis, ileal
30400	Intestinal stenosis, jejunal
30500	Intestinal stenosis, rectal
30600	Intracardiac mass
30700	Intrathoracic vascular ring
30800	Irlen-Cox syndrome
30900	Jackson-Lawler pachyonychia congenita syndrome
31000	Jadossohn-Lewandowski pachyonychia congenita syndrome
31100	Jansen-type metaphyseal dysplasia
31200	Jarcho-Levin syndrome
31300	Johanson-Blizzard syndrome
31400	Jugular lymphatic obstruction sequence
31500	Kabuki syndrome
31600	Kartagener syndrome
31700	Keratoconus
31800	Killian/Teschler-Nicola syndrome (Pallister mosaic syndrome)
31900	Kinky hair syndrome (Menkes Syndrome)
32000	Klein-Waardenburg syndrome
32100	Klinefelter syndrome
32200	Klippel-Feil sequence
32300	Klippel-Trenaunay-Weber syndrome
32400	Kniest dysplasia
32500	Kozlowski spondylometaphyseal dysplasia
32600	Lacrimo-auriculo-dento-digital syndrome
32700	Ladd syndrome
32800	Langer-Gideon Syndrome
32900	Langer-Saldino achondrogenesis
33000	Larsen syndrome
33100	Laryngeal abnormality

ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

33200	Laryngeal atresia
33300	Laryngeal web
33400	Left-sidedness sequence
33500	Lens, dislocation
33600	Lenticular opacity
33700	Lentiginos, multiple
33800	Lenz-Majewski hyperostosis syndrome
33900	Leopard syndrome
34000	Leri-weill dyschondrosteosis
34100	Leroy I-cell syndrome
34200	Lesch-Nylan syndrome
34300	Lethal multiple pterygium syndrome
34400	Levy-Hollister syndrome
34500	Limb-body wall complex
34600	Lipoatrophy
34700	Lipodosis, neurovisceral
34800	Lipodystrophy, generalized
34900	Lipomatosis, encephalocraniocutaneous
35000	Lippit-cleft hip syndrome (Van der Woude Syndrome)
35100	Lissencephaly Syndrome (Miller-Dreker Syndrome)
35200	Lobstein disease
35300	Lupus, neonatal
35400	Macrocephaly
35500	Macroglossia
35600	Macroglyria
35700	Macro-orchidism
35800	Macrosomia
35900	Macrostomia
36000	Madelung deformity
36100	Maffucci syndrome
36200	Malar hypoplasia
36300	Male pseudohermaphroditism
36400	Mandibular hypodontia
36500	Marden-Walker syndrome
36600	Marfan syndrome
36700	Maroteaux-Lamy (mucopolysaccharidosis syndrome)
36800	Marshall syndrome
36900	Marshall-Smith syndrome
37000	Masa syndrome (X-linked hydrocephalus syndrome)
37100	Maternal phenylketonuria, fetal effects
37200	Maxillary hypoplasia
37300	Mccune-Albright syndrome (osteitis fibrosa cystica)
37400	Mckusick type metaphyseal dysplasia
37500	Meckel diverticulum

ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

37600	Median cleft face syndrome
37700	Melanomata
37800	Melanosis, neurocutaneous
37900	Melnick-Fraser syndrome
38000	Melnick-needles syndrome
38100	Meningocele
38200	Meningomylocele
38300	Metacarpal hypoplasia
38400	Metaphyseal dysplasia, Jansen type
38500	Metaphyseal dysplasia, Mckusick type
38600	Metaphyseal dysplasia, Pyle type
38700	Metaphyseal dysplasia, Schmid type
38800	Metatarsal hypoplasia
38900	Metatarsus adductus
39000	Metatropic dwarfism
39100	Metatropic dysplasia
39200	Methioninaemia
39300	Methotrexate embryology
39400	Microcephaly
39500	Microcolon
39600	Microcolon-megacystis-hypperistalsis syndrome
39700	Microcornea
39800	Microdeletion syndrome
39900	Microdontia
40000	Microgastria
40100	Microglossia
40200	Micrognathia
40300	Micropenis
40400	Microphthalmia
40500	Microstomia
40600	Miller syndrome (postaxial acrofacial dysostosis)
40700	Moebius syndrome
40800	Mohr syndrome (OFD)
40900	Morquio syndrome
41000	Mucopolidosis III (pseudo Hurler)
41100	Mucopolysaccharidosis I s (Scheie Syndrome)
41200	Mucopolysaccharidosis III, types a, b, c, d
41300	Mucopolysaccharidosis VII (Sly Syndrome)
41400	Mulibrey nanism syndrome (Perheentupu Syndrome)
41500	Multiple endocrine neoplasia, type 2b
41600	Multiple neuroma syndrome
41700	Multiple synostosis syndrome (Symphalangism Syndrome)
41800	Murcs association

ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

41900	Myasthenia gravis, newborn
42000	Myopathy, centronuclear
42100	Myopathy, myotubular
42200	Nanism, diastrophic
42300	Nasal dysplasia
42400	Neonatal lupus
42500	Neonatal teeth
42600	Nesidioblastosis
42700	Neu-laxova syndrome
42800	Neural tube defect
42900	Neurocutaneous melanosis syndrome
43000	Neurofibromatosis syndrome
43100	Neuromuscular defect
43200	Neurovisceral lipidosis, familial
43300	Noonan syndrome
43400	Occult spinal dysraphism
43500	Oculo-auriculo-vertebral defect spectrum
43600	Oculodentodigital syndrome
43700	Oculo-genito-laryngeal syndrome (Optiz Syndrome)
43800	Odontoid hypoplasia
43900	Oculo-facial-digital syndrome, type I (OFD-I)
44000	Oculo-digital-facial syndrome type III (OFD-III)
44100	Oligohydramnios sequence
44200	Ollier disease (osteochondromatosis syndrome)
44300	Omphalocele
44400	Optic nerve dysplasia
44500	Oromandibular-limb hypogenesis spectrum
44600	Osteochondrodysplasia
44700	Osteodysplasia
44800	Osteogenesis imperfecta, type I
44900	Osteogenesis imperfecta, type II
45000	Osteolysis
45100	Osteo-onychodysplasia
45200	Osteopetrosis
45300	Otocephaly
45400	Oto-palato-digital syndrome, type I (Taybi Syndrome)
45500	Oto-palato-digital syndrome, type II
45600	Pachydermoperiostosis syndrome
45700	Pachygyria
45800	Pachyonchia congenita syndrome
45900	Pallister-Hall syndrome
46000	Parabiotic syndrome, donor (Twin-to-twin transfer)
46100	Parabiotic syndrome, recipient (Twin-to-twin transfer)
46200	Pectus carinatum

ANOMALY/METABOLIC

SYNDROMES AND

CONDITIONS

(R054) (con't)

46300	Pectus excavatum
46400	Pena Shokeir phenotype, type I
46500	Pena-Shokeir phenotype, type II
46600	Penta x syndrome
46700	Pentrology of cantrell
46800	Perinatal lethal hypophosphotasia
46900	Peters'-plus syndrome
47000	Peutz Jeghers syndrome
47100	Pfeiffer syndrome
47200	Phenylketonuria
47300	Phenylketonuria, maternal effects
47400	Photosensitive dermatitis
47500	Pierre Robin syndrome
47600	Pitting, lip
47700	Pitting, preauricular
47800	Poikiloderma congenitale syndrome (Rothmund-Thomson)
47900	Poland sequence
48000	Polydactyly
48100	Polymicrogyria
48200	Polysplenia syndrome
48300	Popliteal pterygium syndrome
48400	Porencephalic cyst
48500	Port wine stain
48600	Potter syndrome
48700	Prader-Willi syndrome
48800	Preauricular tags
48900	Preauricular pits
49000	Prognathism
49100	Porteus syndrome
49200	Pseudoachondroplasia
49300	Pseudocamptodactyly
49400	Pulmonary agenesis
49500	Pulmonary hypoplasia
49600	Pulmonary lymphangectasia, congenital
49700	Pyknodysostosis
49800	Pyle disease (Pyle metaphyseal dysplasia)
49900	Pyruvate carboxylase deficiency
50000	Pyruvate dehydrogenase deficiency
50100	Rachischisis
50200	Ranula
50300	Rectal atresia
50400	Rectal atresia, with fistula
50500	Refsum's disease

ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

50600	Reifenstein's syndrome
50700	Restrictive dermopathy
50800	Retinoic acid embryopathy
50900	Rhizomelic chondrodysplasia punctata
51000	Rieger syndrome
51100	Right-sidedness sequence
51200	Rokitansky malformation sequence
51300	Rubinstein-Taybi syndrome
51400	Russell-Silver syndrome (Silver Syndrome)
51500	Saddle nose
51600	Saethre-Chotzen syndrome
51700	Salino-noonan short rib-polydactyly syndrome
51800	Sc phocomelia
51900	Schinzal-Giedion syndrome
52000	Schimd type metaphyseal dysplasia
52100	Schizencephaly
52300	Sclerosteosis
52500	Scrotum, shawl
52600	Seckel syndrome
52700	Septo-optic dysplasia sequence
52800	Short bowel syndrome
52900	Short rib-polydactyly syndrome, type II
53000	Shprintzen syndrome
53100	Shwachman syndrome
53200	Simpson-Golabi-Behmel syndrome
53300	Sirenomelia sequence
53400	Smith-Lemli-Opitz Syndrome
53500	Spondylometatarsal synostosis syndrome
53600	Spondylometaphyseal dysplasia
53700	Spondylometaphyseal dysplasia, Kozlowski
53800	Stenial malformation-vascular dysplasia spectrum
53900	Struge-Weber sequence
54000	Sulfite oxidase deficiency
54100	Sugarman syndrome
54200	Syndactyly
54300	Tar syndrome (thrombocytopenia absent radius)
54400	Taurodontism
54600	Tdo syndrome
54700	Testicular feminization syndrome
54800	Tesetis, hydrocele
54900	Tethered cord malformation syndrome
55000	Thanatophoric dysplasia
55100	Thyroglossal cyst
55200	Thrombocytopenia absent radius syndrome

ANOMALY/METABOLIC
SYNDROMES AND
CONDITIONS
(R054) (con't)

55300 Thurston syndrome
55400 Tibial aplasia-ectrodactyly syndrome
55500 Townes-brock syndrome
55600 Tracheoesophageal fistula
55700 Transcobalamin II deficiency
55800 Trapezoidcephaly
55900 Tricho-rhino-phalangeal syndrome, type I
56000 Tridione embryopathy
56100 Trimethadione embryopathy
56200 Triphalangeal thumb
56300 Triploidy
56400 Trp I
56500 Turner syndrome
56600 Turner-like syndrome
56700 Umbilical hernia
56800 Urorectal septum malformation sequence
56900 Uterus, ambiguous
57300 Vagina, double
57400 Valproate embryopathy
57500 Varadi-Papp syndrome
57600 Vater association
57700 Vein of Galen, aneurysm
57800 Vertebral defect
57900 Volvulus, colon
58000 Volvulus, ileum
58100 Volvulus, jejunum
58200 Volvulus, small bowel
58300 Von Hippel-Lindau syndrome
58400 Vrolik disease
58500 Waardenburg syndrome, type I
58600 Waardenburg syndrome, type II
58700 Waardenburg syndrome, type III
58800 Wagr syndrome
58900 Walker-Warburg syndrome
59000 Warfarin embryology
59100 Weaver syndrome
59200 Weill-Marchesani syndrome
59300 Werner syndrome
59400 Whelan syndrome
59500 Williams syndrome
59600 Xeroderma pigmentosa syndrome
59700 Yunis-Varon syndrome
59800 Zellweger syndrome
59900 Zollinger-ellison syndrome

**DUCTUS SYNDROME OF
PREMATURITY**
(patent ductus arteriosus)
(R057)

Found on the '*DISCHARGE SUMMARY*'.

Choose **one** of the following;

- 100 Non-surgical closure
- 200 Surgical closure
- 300 Treatment not stated

**PERSISTENT FETAL
CIRCULATION/
PERSISTENT PULMONARY
HYPERTENSION OF THE
NEWBORN**
(R058)

Found on the '*DISCHARGE SUMMARY*'.

Choose **one** of the following causes;

- 100 Congenital heart disease
- 200 Fetomaternal bleed
- 300 Hyaline membrane disease
- 400 Meconium aspiration
- 500 Pulmonary hypoplasia
- 600 Pneumonia
- 700 Primary pulmonary hypertension
- 800 Cause not stated

**RESPIRATORY DISTRESS
SYNDROMES**
(R059)

Found on the '*DISCHARGE SUMMARY*'.

Choose **one** of the following;

- 100 Transient respiratory distress
- 200 IRDS, mild
- 300 IRDS, moderate
- 400 IRDS, severe
- 500 IRDS, severity not stated
- 600 Transient Tachypnea of the newborn
- 700 Benign respiratory distress

**CHRONIC PULMONARY
DISEASE OF PREMATURITY
(R060)**

Found on the '*DISCHARGE SUMMARY*'.

Choose **one** of the following;

- 100 Wilson-Mikity syndrome, non-cystic
- 200 Wilson-Mikity syndrome, cystic
- 300 Bronchopulmonary dysplasia, non-cystic
- 400 Bronchopulmonary dysplasia, cystic

**REQUIREMENT FOR HOME
OXYGEN
(R061)**

Found on the '*DISCHARGE SUMMARY*'.

- 100 Patient requires home oxygen.

**BIRTH ASPHYXIA SEQUELLA
(R062)**

Found on the '*DISCHARGE SUMMARY*'.

Choose as many as are present.

- 100 Post-Asphyctic CNS Depression
- 200 Post-Asphyctic CNS Excitation
- 300 Post-Asphyctic Increase Intracranial Pressure
- 400 Post-Asphyctic Brain Necrosis
- 500 Post-Asphyctic Congestive Heart Failure
- 600 Post-Asphyctic Acute Tubular Necrosis
- 700 Post-Asphyctic Liver and/or Adrenal Necrosis

CONVULSIONS/SEIZURES

(R063)

Convulsions or seizures due to a stated condition.

Found on the 'DISCHARGE SUMMARY'.

Choose as many as are present.

- 100 Alkalosis
- 200 Arhinencephaly
- 300 Benign Familial
- 400 Brain Edema
- 500 Cerebral Anomaly, Unspecified
- 600 Drug Withdrawal
- 700 Hemorrhage, Brain Stem
- 800 Hemorrhage, Cerebellar
- 900 Hemorrhage, Cerebral
- 1000 Holoprosencephaly
- 1100 Hydrocephaly
- 1200 Hydranencephaly
- 1300 Hypercapnia
- 1400 Hypocalcemia
- 1500 Hypocapnia
- 1600 Hypoglycemia
- 1700 Hypomagnesemia
- 1800 Hyponatremia
- 1900 Inborn Error of Metabolism
- 2000 Infarction
- 2100 Kernicterus
- 2200 Meningitis
- 2300 Post-asphyctic
- 2400 Pyridoxine Deficiency
- 2500 Pyridoxine Dependency
- 2600 Unknown
- 2700 Venous Thrombosis

NEOPLASMS**(R064)**

Found on the 'DISCHARGE SUMMARY'.

Code all that are applicable.

100	Astrocytoma
200	Choroid Plexus Papilloma
300	Connective Tissue
400	Craniopharyngioma
500	Cystadenoma
600	Cystic Hygroma
700	Endothelial Tissue
800	Ependymoma
900	Epithelial Tissue
1000	Familial Erythrophagocytic Lymphohistiocytosis
1100	Fibroma
1200	Follicular Cyst
1300	Glioma
1400	Hemangioma, Cavernous
1500	Hemangioma, Capillary
1600	Hepatoblastoma
1700	Histiocytosis
1800	Insulinoma
1900	Leukemia
2000	Lipoma
2100	Lymphangioma
2200	Lymphoma
2300	Mass, Unknown Type
2400	Medulloblastoma
2500	Melanoma
2600	Melanotic Neuroectodermal Tumor
2700	Mesoblastic Nephroma
2800	Muscle
2900	Myxofibrosarcoma
3000	Nasal Glioma
3100	Nephroblastoma
3200	Nesidioblastosis
3300	Neuroblastoma
3400	Neuroectodermal Tumor
3500	Neurofibroma
3600	Retinoblastoma
3700	Rhabdomyoma, Cardiac
3800	Rhabdomyoma

NEOPLASMS**(R064)** (con't)

3900	Sarcoma
4000	Teratoma, Cardiac
4100	Teratoma, Embryotic Rests
4200	Teratoma, Gonads
4300	Teratoma, Sacrococcygeal
4400	Teratoma, Site Not Specified
4500	Wilm's Tumor
4600	Hemangioma
4700	Hemangioma, port-wine

MEDICATIONS**(R066)**

(Not coded at IWK)

Found on '*Medication Sheets*' or '*Discharge Summary*'

400	Acyclovir
500	Adenosine
600	Adrenalin
1000	Alprostadel (Prostagladin e.; Prostin)
1400	Amoxicillin
1600	Ampicillin
3100	Cefazidime
3200	Cefazolin
3300	Cefotaxime
3400	Ceftriaxone
3500	Cefuroxime
4000	Cloxacillin
4200	Colfosceril palmitate [Exosurf] Cortisol (Exosurf [Surfactant])
4600	Diazepam
4800	Digoxin
4900	Dilantin (Phenytoin)
5000	Dobutamine
5200	Dopamine
5400	Epinephrine
5600	Erythromycin
5700	Fentanyl
5900	Flagyl (Metronidazole)
6300	Furosemide (Lasix)
6400	Gentamicin
6500	Glucagon
7500	Insulin
7800	Kayexalate
8700	Morphine
8800	Naloxone (Narcan)
9500	Penicillin

MEDICATIONS

(R066) (con't)

(Not coded at IWK)

9600	Phenobarbital
9700	Potassium chloride
10000	Propranolol
10300	Salbutamol (Ventolin)
10400	Sepra (Sulfamethoxazole/trimethoprim)
11100	Ticarcillin
11200	Tobramycin
11400	Trimethoprim
11700	Vancomycin

DRUG WITHDRAWAL FROM

MATERNAL USE

(R067)

Found on the '*Discharge Summary*'

Code ALL applicable drugs

100	Alprazolam (Xanax)
200	Barbituate
300	Benzodiazepam
400	Citalopram (Celexa)
500	Cocaine
600	Diazepam (Valium)
700	Fluoxetine (Prozac)
800	Ethchlorvryol (Placidyl)
900	Heroin
1000	Hydromorphone (Dilaudid)
1100	Lorazepam (Ativan)
1200	Meperidine (Demerol)
1300	Methadone
1400	Morphine
1500	Oxazepam
1600	Paroxetine (Paxil)
1700	Pentazocine (Talwin)
1800	Sertraline (Zoloft)
1900	Unknown
2000	Venlafaxine (Effexor)
2010	OxyContin

**CENTRAL VENOUS
CATHETERS**
(R069)

Found on the '*OPERATIVE REPORT*' or on the '*DISCHARGE SUMMARY*'.

Code ALL that are applicable.

100	Umbilical vein, direct
200	Upper limb, direct
300	Upper limb, percutaneous (PICC)
400	Upper limb, cut down (surgical)
500	Upper limb, Broviac
600	Lower limb, direct
700	Lower limb, percutaneous (PICC)
800	Lower limb, cut down (surgical)
900	Lower limb, Brioviac
1000	Other

ARTERIAL CATHETERS
(R070)

Found on the '*OPERATIVE REPORT*' or on the '*DISCHARGE SUMMARY*'.

Code ALL that are applicable.

100	Umbilical, direct
200	Radial, direct
300	Radial, percutaneous (PICC)
400	Radial, cut down (surgical)
500	Pedal, direct
600	Pedal, percutaneous (PICC)
700	Pedal, cut down (surgical)
800	Femoral, direct
900	Femoral, percutaneous (PICC)
1000	Femoral, cut down (surgical)

MODE OF VENTILATION
(R071)

Found on the '*RESPIRATORY THERAPY RECORD*' or on the '*DISCHARGE SUMMARY*'.

Code ALL that are applicable.

- 100 Intermittent mandatory ventilation (IMV)
- 200 Synchronized mandatory ventilation (SIMV)
- 300 Pressure support (PS)
- 400 Continuous positive airway pressure (CPAP)
- 500 High frequency Oscillatory ventilation (HFOV)
- 600 Positive pressure ventilation (PPV)

**COMPLICATIONS OF
ENDOTRACHEAL INTUBATION
(R072)**

Found on the '*DISCHARGE SUMMARY*'.

Code ALL complications of an endotracheal intubation that are applicable.

100	Esophageal perforation
200	Granuloma
300	Laryngeal perforation
400	Laryngeal stenosis
500	Lip deformity
600	Necrotizing laryngitis
700	Necrotizing tracheitis
800	Palate deformity
900	Squamous metaplasia
1000	Stridor
1100	Subglottic stenosis
1200	Tracheal perforation
1300	Tracheobronchomalacia
1400	Ulceration

**VASCULAR CATHETERS
(R073)**

Found on the '*OPERATIVE REPORT*' or on the '*DISCHARGE SUMMARY*'.

Code ALL complications of a vascular catheter that are applicable.

100	Arterial thrombosis
200	Cardiac tamponade
300	Edema
400	Loss of finger(s)
500	Loss of toe(s)
600	Pericardial effusion
700	Perforation of the heart
800	Pleural effusion
900	Phrenic nerve palsy
1000	Ruptured vessel
1100	Thrombophlebitis
1200	Vasospasm
1300	Venous thrombosis

NASO/ORO GASTRIC TUBES
(R074)

Found on the '*DISCHARGE SUMMARY*'.

Code ALL complications of a naso/oro gastric tube that are applicable.

- 100 Perforation, esophagus
- 200 Perforation, stomach
- 300 Perforation, small bowel

COMPLICATIONS OF
MEDICATIONS
(R075)

Found on the '*DISCHARGE SUMMARY*'.

Code ALL applicable complications due to a medication.

- 100 Cardiomyopathy, steroid induced
- 200 Contracture, secondary to IM injection
- 300 Nephrocalcinosis, diuretic induced
- 500 Skin slough

COMPLICATIONS OF
SURGERY
(R076)

Found on the '*OPERATIVE REPORT*' or on the '*DISCHARGE SUMMARY*'.

Code ALL applicable complications due to a surgical procedure.

- 100 Diaphragmatic paralysis
- 200 Vocal cord paralysis

BURNS
(R077)

Found on the '*DISCHARGE SUMMARY*'.

Code ALL applicable burns.

- 100 Chemical
- 200 Electrical
- 300 Thermal

PHOTOTHERAPY
(R078)

Found on the '*DISCHARGE SUMMARY*'

100 Phototherapy

IMMUNIZATIONS
(R079)

Found on the '*DISCHARGE SUMMARY*'

Code ALL applicable immunizations given to the infant.

100 DPTP (Diphtheria, Pertussis, Tetanus, Polio)
200 DPT (Diphtheria, Pertussis, Tetanus)
300 Hepatitis B globulin
400 Hepatitis B vaccine
500 Viral Influenza
600 Hemophilus Influenza B Conjugate
700 RSV (Respiratory Syncytial Virus) Vaccine
800 Varicella (Chicken Pox) Vaccine

LAB RESULTS**(R080)**

(Not coded at IWK)

(Refer to reference lab sheet for ranges)

Found on 'Discharge Summary or Lab Sheets'

- 100 Neutropenia,
 < 1,000 pmns (mature or bands per cu.mm)
use following formula:
 Multiply the total corrected WBC's by the % of
 pmns (polymorphoneutrophils) and bands.
- e.g. total WBC= 15,000
 pmns= 5%
 bands= 1%
- 200 ABO Immunizations- Definite
 300 D isoimmunization
 400 Little c Isoimmunization
 500 Big C Isoimmunization
 600 Big E Isoimmunization
 700 Kell Isoimmunization
 800 Fya Isoimmunization (Duffy)
 900 Kidd
 1000 Wright
 1100 MNS blood groups
 1200 Positive DAT
 1300 Misc. Isoimmunization - Little "e"
 1400 Misc. Isoimmunization - Little "s"
 1500 Hyperbilirubinemia
**(Total bilirubin > 15 mg% or > 258 microM/L;
 or unconjugated or indirect bilirubin ≥ 230
 microM/L)**
- 1600 Anemia
**Hgb < 14 gm% or <140 g/L or Hct < 42% in
 the first week;
 Hgb < 10 gm% or <100 g/L or Hct < 30% at
 Any age.
 Code the cause based on the first low
 hemoglobin, unless clearly stated
 otherwise.)**
- 1700 Polycythemia
**(Central Hgb >21 gm% (210 g/L), central Hct
 >63% (.630 L/L),
 capillary Hgb >25 gm% (250 g/L), or capillary
 Hct >75% (.750 L/L);both Hgb and Hct must
 be above normal on a single sample, or at
 least one of Hgb or Hct is above normal on 2
 or more consecutive samples.)**

LAB RESULTS

(R080) (con't)

1800	Thrombocytopenia (Platelet count <100,000 on greater than two occasions only)
1900	Obstructive Jaundice (Direct bilirubin , or conjugated, >2.0 mg% or >34.5 micromol/L)
2000	Increased nucleated RBC and/or normoblastemia >15% or greater than 18 nRBCs on 0-5 days; >1% or greater than 2 NRBCs after 5 days)
2100	Reticulocytosis (>7% on days 1-2; >5% on days 3-6; >3% on days 7 and thereafter)
2200	Hyperthyroidism
2300	Rickets - Elevated alkaline phosphatase only (>406 I.U.)
2400	Hypoglycosemia (<30 mgm% or <1.67 mmol/L)
2500	Hyperglycosemia (>125 mg% or >6.94 mmol/L)
2600	Hypocalcemia (7.0 mg% or less; 1.75 mmol/L or less; ionized \leq 1.0 mmol/L)
2700	Late Metabolic Acidosis (After 72 hours of age; base deficit > -10 mEq/L or > -10 mmol/L)
2800	Hypokalemia (<3.0 mEq/L or <3.0 mmol/L)
2900	Hyperkalemia (7.0 mEq/L or more; 7.0 mmol/L or more)
3000	Hyponatremia (130 mEq/L or less; 130 mmol/L or less)
3100	Hypernatremia (>155 mEq/L or >155 mmol/L)
3200	Azotemia (BUN 20 mg% or more; 7.14 mmol/L or more, urea value)
3300	Hypercreatininemia 2.0 mg% or more; 177 micromol/L or more)
3400	Oliguria (<15 ml/Kgm/day on Day 2 or <20 ml/Kgm/day after 2 days)
3500	Hypoproteinemia (4.0 gm% or less; 40 gm/L or less)

LAB RESULTS

(R080) (con't)

3600	Hypoalbuminemia (≤ 2.4 gm% or ≤ 24 gm/L)
3700	Hypomagnesemia (1.3 mEq/L or less; 0.53 mmol/L or less)
3800	Hypermagnesemia (>2.5 mEq/L or >1.03 mmol/L)
3900	Hyperphosphatemia (8.0 mg% or more; 2.58 mmol/L or more)
4000	Hypertyrosinemia (5.0 mgm% or more)
4100	Hyperammonemia (>150 microgm% or >107 micromol/L)
4200	Hyperuricemia (>400 micromol/L)
4300	Hypercalcemia (≥ 3.0 mmol/L; ionized - ≥ 1.5 mmol/L)
4400	Low serum alkaline/phosphatase (< 120 IU/L)
4500	Hypophosphatemia (<4.0 mg% or <1.29 mmol/L)

INTRA-VENTRICULAR

HEMORRHAGE

(R081)

Found on the 'Discharge Summary'

100	Grade 1 (sub-ependymal, choroid Plexus hemorrhage)
200	Grade 2 (Hemorrhage into ventricle without dilatation of ventricle)
300	Grade III (Hemorrhage into ventricle with dilatation of ventricle)
400	Grade IV (Hemorrhage into brain: thalamic hemorrhage, cortical hemorrhage)

TRAUMA
(R082)

Found on the 'Discharge Summary'

Code **ALL** applicable traumas

100	Fracture Clavicle
200	Fracture Femur
300	Fracture Humerus
400	Fracture Other
500	Fracture Rib (s)
600	Fracture Skull
700	Cephalohematoma Left
800	Cephalohematoma Right
900	Cephalohematoma Bilateral
1000	Cephalohematoma Other, including Occipital
1100	Cephalohematoma Unknown
1200	Shoulder Dystocia

NON-SPECIFIC
NEUROLOGICAL FINDINGS
(R083)

Found on the 'Discharge Summary'

Code **ALL** applicable Findings

100	Abnormal Cerebral Irritation/Hypertonicity
200	Hyperreflexia (Hereditary Startle Disease)
300	Abnormal Cerebral Depression/Hypotonicity
400	Abnormal Cerebral Depression due to Maternal Analgesia
500	Cerebral Edema
600	Cortical Atrophy
700	Encephalomalacia
800	Gilles Telencephalic Leukoencephalopathy
900	Infarction
1000	Porencephalic cyst(s)
1100	Periventricular Leukomalacia

OTHER SPECIFIC
NEUROLOGICAL FINDINGS
(R084)

Found on the '*Discharge Summary*'

Code **ALL** applicable Findings

100	Facial Palsy Left
200	Facial Palsy Right
300	Facial Palsy Bilateral
400	Brachial Plexus (Erb's & Klumpke's) Palsy, Left
500	Brachial Plexus (Erb's & Klumpke's) Palsy, Right
600	Brachial Plexus (Erb's & Klumpke's) Palsy, Bilateral
700	Brachial Plexus (Erb's & Klumpke's) Palsy, Radial Nerve (Wrist Drop)
800	Phrenic Nerve, Left
900	Phrenic Nerve, Right
1000	Phrenic Nerve, Bilateral
1100	Hemiparesis Transient (NOT present at time of discharge from hospital)
1200	Hemiparesis Transient (Present at time of discharge from hospital)
1300	Retinal hemorrhage involving the macula
1400	Chorioretinitis
1500	Congenital Subdural Effusion
1600	Periventricular Calcification
1700	Ondines's Curses
1800	Opsoclonus
1900	Cranial Nerve Palsy 3 rd or Oculomotor Nerve
2000	Cranial Nerve Palsy 4 th or Trochlear Nerve
2100	Cranial Nerve Palsy 5 th or Trigeminal Nerve
2200	Cranial Nerve Palsy 6 th or Abducens Nerve
2300	Cranial Nerve Palsy 10 th or Vagus Nerve

APNEA
(R085)

Found on the "*Discharge Summary or Nurses Notes*'

100	Apneic Spells
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RESUSCITATION AT DELIVERY
(R086)

Found on the *'Birth Record or Discharge Summary'*

Code **ALL** applicable codes

100	Oxygen
300	Chest Compressions
400	Medications

INDEX OF MATERNAL DISEASES AND PROCEDURES

- A -

	CODE #
Abruptio placenta:	
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Tdo syndrome	R054
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Teratoma, Embryotic Rests	R064
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Teratoma, Sacrococcygeal	R064
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Thanatophoric dysplasia	R054
Thyroglossal cyst	R054
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Thurston syndrome	R054
Tibial aplasia-ectrodactyly syndrome	R054
Townes-brock syndrome	R054
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Tracheobronchomalacia, complication of Endotracheal tube	R072
Tracheoesophageal fistula	R054
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Trimethadione embryopathy	R054
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- T cont -

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True knot in cord, placenta	R051
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Twins:	
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dichorionic, similar sexes and blood groups	pg.71
dichorionic, similar sexes, blood groups undetermined	pg.71
monoamniotic	pg.71
monochorionic, diamniotic	pg.71
Siamese (Conjoined)	pg.71
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- U -

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- V -

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DPT	R079
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Respiratory syncytial virus	R079
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Viral Influenza	R079
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Vasa previa, placental anomaly	R051

- V cont-

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Arterial thrombosis	R073
Cardiac tamponade	R073
Edema	R073
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Loss of toe(s)	R073
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- W -

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Williams syndrome	R054
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Wilson-Mikity syndrome	
cystic	R060
non-cystic	R060

- W cont-

Withdrawl due to maternal use:

Alprazolam (Xanax)	R067
Barbituate	R067
Benzodiazepam	R067
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Cocaine	R067
Diazepam (Valium)	R067
Fluoxetine (Prozac)	R067
Ethchlorvyol (Placidyl)	R067
Heroin	R067
Hydromorphone (Dilaudid)	R067
Lorazepam (Ativan)	R067
Meperidine (Demerol)	R067
Methadone	R067
Morphine	R067
OxyContin	R067
Oxazepam	R067
Paroxetine (Paxil)	R067
Pentazocine (Talwin)	R067
Sertraline (Zoloft)	R067
Unknown	R067
Venlafaxine (Effexor)	R067
Wright-isoimmunization	R080
Wrist Drop	R084

- X -

Xeroderma pigmentosa syndrome	R054
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- Y -

Yunis-Varon syndrome	R054
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- Z -

Zellweger syndrome	R054
Zollinger-ellison syndrome	R054